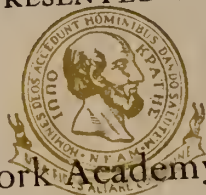




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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

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Number 1

## Looking Backward Over Fifty Years of Health Work in Florida\*

JOSEPH Y. PORTER, M.D.,

*Former State Health Officer of Florida,*

1889 - 1917

*Serial No. 1*

In speaking of happenings in health matters covering a period of fifty years and over, without having records at hand to consult, is quite a difficult task, as memory must be relied upon to verify incidents and memory is not infrequently tricky and capricious. This is especially true when it is desired to be particularly accurate in establishing certain details of methods or occurrences, such as dates. Therefore, he who reads this partial narrative must make due allowance for forgetfulness, and is asked to supply many omissions, which no doubt he may be able to recall from his own remembrances.

Florida has functioned as a state under three Constitutions: 1838, formed at St. Josephs, on bay of the same name; Western Coast of Florida, 1868, by Carpet Bag Government, after the war between the states; and 1885, the present Constitution, which was ratified at the general election of November, 1886. Until the present Constitution was framed, there had been no mention hitherto of any ordinance of article affecting the public health of the state. That subject of administration seems to have been deliberately ignored by the older statesmen of Florida or else overlooked by them. Every other method or duty, apparently necessary to the peace, comfort or property protection of the inhabitants of the state, appears to have been given due consideration and provided for in a peaceful and law-abiding manner; but the health of the citizen seems to have been given but little consideration by the lawmakers in the early days of statehood. When the Constitutional Convention of 1885, held at Tallahassee during the early summer of that

year, assumed the task of revising the several powers and what should be the delegated authority of the people to the legislative branch of state government, a member from Hillsborough County, Dr. John P. Wall of Tampa, and an ex-president of the Florida Medical Association, insisted that no longer should the state be silent on the question of proper and adequate laws respecting the conservation of the health of the people of the state, nor in providing an authority by which disease agencies created or arising within or without the state might be suppressed or prevented. It was due to Dr. Wall's insistence on the floor of that convention that an ordinance was prepared on the subject and adopted, and afterwards ratified in the text of the Constitution in 1886. This is Article 19 of the present Constitution and stands as a lasting memorial to a man of superior mental attainments and who, far ahead of his times, was looking forward to the future welfare and commercial prosperity of his native state, for Dr. Wall was born in Hamilton County.

Notwithstanding the fact that the ratification of the Constitution referred to contained the article relating to the public health, the legislature of 1887 adjourned without taking any action towards complying therewith, although yellow fever had been reported in Key West in April, and the president of the State Medical Association that year, after adjournment of the meeting in St. Augustine, went at once to Tallahassee and laid before the Governor what he considered to be an urgent necessity for immediate action to secure legislation for a Central State Health Department or Bureau. The history of the epidemic of that year in Key West and the subsequent passing of the disease to Tampa in the fall of 1887, lingering throughout the winter, which was

\*Read by title before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg, May 19-20. Owing to the length of this paper, it will appear in THE JOURNAL in seven serials beginning with Serial Number One of this issue.



mild in temperature, traveling slowly up the state in sporadic outbreaks and culminating finally in violent outbreak at Jacksonville in August, 1888, although an occurrence of some thirty-eight years ago, it has not yet been entirely forgotten by those now living, who passed through the heartrending experiences of that period.

The fall of 1888 was a political campaign year in the state and the difficulty experienced in travel, going from one county into another, with a "hold up" at each county line, demands for identification cards and "health certificates" of previous daily stops, are tales that grandparents tell their grandchildren with embellishment of conditions which existed in health management nearly half a century ago. The late Governor Francis P. Fleming was a candidate for the governorship of Florida during that political campaign. A nomination by the State Democratic Convention was then equivalent to an election; but, nevertheless, the candidates for all of the important offices to be elected were expected to visit the different sections of the state and set forth to the public what policies of state administration they proposed to advocate. The statehood party that year had great difficulty in getting about the state, for fear and panic are no respectors of individuals nor the high office to which they might aspire. The candidates were not infrequently stopped at a county line and sometimes turned back. Especially was this the case if on the eastern or at the southern end of the peninsula. They were closely scrutinized as to where they came from and how long they remained in any one place, that the infection of yellow fever might not lie hidden and be brought in their person on their clothing. It must not be forgotten that the state, not having a central health governing department or bureau, relied for a degree of protection against the spread of contagiously infectious diseases on the county boards of health, which were given ample authority to provide rules and regulations to be observed by the public in travel and passing of goods from supposedly infected centers from nearby places of other states. Accordingly, during the yellow fever epidemic period of the summer of 1888, each county, by its county board of health, placed in active operation a quarantine against an adjoining county or counties in which yellow fever was known to exist. Oftentimes the rumor did not wait to be verified by absolute or unquestioned information, but supposition or

imagination, stirred by fear, was sufficient to prevent by armed force any traveler from one county to another. Nor was this "shot-gun" quarantine confined altogether to the territory where the "fever" was known to prevail but extended to sections remote and far separated from the infected territory. It is almost unbelievable, except to those who actually witnessed the fright of the people at the mere mention of yellow fever, the unwarrantable measures adopted, bordering in many instances on the ridiculous and in others to inhuman cruelty, to escape the supposed danger of contracting the disease. For instance, flat cars loaded with iron rails were held up on siding enroute from Jacksonville to Tallahassee and likewise a boxcar load of ice in the same course of transportation, under fear of conveying yellow fever poison because coming from Jacksonville. The writer was threatened if he attempted to pass on an engine through one of the counties lying between Duval and an adjoining county to visit the sick at a small settlement between Baldwin and Starke. He was informed that he would be shot at because he had been in contact with yellow fever patients in Jacksonville. Numerous other instances of the same description of "man's inhumanity to man" could be named, but it suffices to say that the fall of 1888 was one of constant dread, actual fright and brutal instances of neglect, where a member of a family deserted home and a sick wife and children because of uncontrollable fear. Panic is a weapon of no mean strength in inflicting injustice, and fear begotten of the panicky condition which prevailed at that time carried an irresponsibility of action which to a rationally acting mind was difficult to understand. It was not surprising, therefore, that the late Governor Fleming, who was campaigning for election to the governorship of the state during those fall months, should have been impressed with the chaotic condition of affairs and the decided need of a harmonious coordination of an experienced knowledge of sanitation—the lack of which he daily witnessed in his attempts to keep dates for speaking in different counties—that he wisely signalled his first official act after taking the oath of office as Governor, by calling together the Legislature in "special session" to deliberate and act upon that provision of the Constitution which sought to correct just such conditions as he witnessed and encountered during the preceding fall months.

It will be remembered by some of the citizens of the state, now living, who were active in polit-

ical matters at that time, that there was a decided opposition, even among the Governor's closest friends, to calling a "special session" of the Legislature when the regular session was to convene in April—only four months off. But Governor Fleming feared that there might be a recrudescence of yellow fever in the early spring months as had been the case the previous year, and he wished, so he said, to anticipate the disturbed commercial and travel condition of the state which had prevailed the previous year by early placing in operation an organization which would administer protective measures freed from extreme fear or unreasonable restrictions. Governor Fleming took a decided stand on this question, principally on his own volition and initiative, and the "special session" by a joint committee of Senate and House, presided over by Senator Hammond of Orange County, framed a bill containing provisions which were considered at that time imperative requirements for health protection and supervision of the state for the coming summer season at least, and when passed and approved of by the Governor on the twentieth

day of February, 1889, was known as an Act providing for and establishing a State Board of Health. A few years previous to the passage of this Act, during Governor Bloxham's administration, a sale of four million acres of state land at twenty-five cents an acre had been perfected to the Disston Company of Pennsylvania, which at that time was thought to have been a wise financial transaction on the part of the then state administration as helping to build up the money resources of the state treasury, which were greatly depleted during the Reconstruction period immediately following the war between the states. But it can be better said now, that bringing into action a neglected mandate of the Constitution, by which the citizens of the state were given protection to life and health so necessary to the full development of the state's wonderful resources, was a triumph of executive foresight commendable in its act, as well as publicly a deep concern in the health and welfare of the citizens of the state.

*(To be Continued)*

## OBSERVATIONS RELATING TO FEEDING OF CHILDREN WITH BACILLARY DYSENTERY

J. D. LOVE, M.D.,

Jacksonville, Florida.

The diverse opinions of physicians relative to the proper feeding of children suffering from bacillary dysentery accounts for the presentation of a paper giving the writer's conclusions based on the observation of twenty-seven cases of bacillary dysentery during the summer of 1924, in which either the proven or presumed etiological factor was infection with Shiga's bacillus.

In certain sections of the South, bacillary dysentery has for many years proven the greatest scourge to which infants and children are subject, and in sections of this state the toll it exacts in the spring and summer months is to the highest degree appalling, the morbidity and mortality being so high that in certain small communities with unscreened houses and inadequate sewerage there is an annual decimation of the childhood population.

Since it is generally conceded that medicine accomplishes but little in these cases, our present reliance must of necessity be placed on such feed-

ing that will prolong life until a resistance has been established against the offending bacteria. Differences of opinion concerning the feeding of children with bacillary dysentery are probably accounted for through the fact that among many physicians there is a misconception as to what constitutes bacillary dysentery. That it is a distinct disease entity has been abundantly proven by competent observers, none of whom have recently thrown more light on the subject than Davison, of Baltimore.

It is unfortunate that many cases of simple dysentery and diarrhea, due either to food injury or infection with comparatively benign bacteria, have been confused with bacillary dysentery, have been diagnosed as such, and have responded to almost any rational dietary. Thus, in many instances false conclusions have been drawn as to the value of certain diets in the management of the disease. The statement by Dr. Harper, that most Southern physicians prefer a carbohydrate diet in the treatment of bacillary dysentery, is without a doubt correct; but since it has been proven that this is a distinct disease entity, I see no reason why there should exist sectional differences of opinion regarding the selection of



appropriate diet in the management of the disease. When, in the treatment of any disorder, there exists essentially divergent views concerning either medication or diet, it almost invariably means that any method proves satisfactory, or that none are availing. This may explain the differences of opinion that exist among competent observers in all sections of the country respecting the proper feeding of children suffering with bacillary dysentery.

I am able to report twenty-seven cases of bacillary dysentery which came under my observation during the past summer, with conclusions which the course of the disease, as influenced by different diets, seems to justify.

Preliminary to report, I would say that the Shiga bacillus was not demonstrated in all of these cases, nor was the agglutination test applied to all. Through the courtesy of Dr. B. L. Arns, of the Florida State Board of Health Laboratory, cultures were first obtained from the stools of a child suffering with bacillary dysentery, and a bacillus was isolated which conformed morphologically to Shiga bacillus. Known strains of Shiga, Flexner and Mt. Dessert bacilli were obtained, and the blood of children suffering from dysentery not only agglutinated the Shiga bacillus but in like manner the bacillus that had been isolated from the stools. We recognize the possibility of error in our conclusions through insufficient cultures from the stools, but since all of the cases we are reporting apparently belonged clinically to the same type of dysentery, it is a reasonable assumption that practically all of them were infected with the same organism.

Out of the twenty-seven cases we are reporting, there were ten deaths, a mortality of 37 per cent. Eleven of the children were fed on a mixed carbohydrate and protein diet, and of this number there were five deaths, a mortality of 45 per cent. Thirteen of the children were fed on carbohydrate food exclusively, and of this number there were but three deaths, a mortality of 23 per cent. In the first series there were three breast-fed children, two of whom died. Contrasting the low mortality of the children fed exclusively on carbohydrates, with the high mortality of those given a mixed carbohydrate and protein diet, the evidence shows either the convincing superiority of carbohydrate feeding, or the number of cases reported is too small from which to draw positive conclusions.

The carbohydrate food employed consisted of cereal gruels, to which was added either one of the maltose-dextrin preparations, milk sugar,

cane sugar, or dextrin. It was interesting to observe that those children fed on this dietary maintained a fair degree of strength and nutrition, notwithstanding the inadequate and entirely unbalanced diet that was employed. In order to prevent tissue cell injury, it has been our practice to add protein to the diet so soon as the patient's condition permits, and we have found this to be a hazardous undertaking unless the infectious element has been overcome. I have repeatedly seen children, who were fairly convalescent under a carbohydrate regimen, show an alarming reaction to so little as one ounce of protein milk given in two feedings three hours apart. That these children so quickly react to a protein feeding can, in our opinion, be explained by the fact brought out by Marriott and Davison, that the Shiga bacillus in cases of bacillary dysentery may be found abundantly in the duodenum, jejunum, and ileum. The Shiga, being a facultative bacteria, thus may produce toxins from protein elements almost from the time the food leaves the stomach until it has passed through the small intestine.

The protein food employed in the cases reported was either protein milk, casein, fat-free buttermilk, or fat-free lactic acid milk of Marriott. No matter what preparation was selected, I could see no appreciable difference in the results that followed, and in all cases they were distinctly bad. Knowing the inhibitive action of lactic acid milk on the growth of bacteria even of the dysentery group, we were disappointed in the results following its employment; and our explanation for failing to secure hoped-for results is that when lactic acid milk becomes mixed with neutral duodenal contents and the alkaline contents of the jejunum and ileum, the power of this agent to inhibit bacterial growth is modified or completely lost. Certainly we cannot assume that this agent, as valuable a food as it is, or any other agency so far known, can exert any marked antiseptic action throughout the course of the alimentary canal. We believe that in bacillary dysentery no spectacular results can be expected from the employment of any food, no matter what its nature, for neither by feeding nor medication can we hope to destroy or inhibit the activity of the bacteria which have invaded the intestinal mucosa and possibly the circulating fluids of the body and therein are constantly producing their toxins.

Our conclusion is that the greatest good, and the least harm, follow the administration of an essentially carbohydrate diet, and that the ten-



year-old teaching of Morse and Talbott, founded on the still undisputed work of Kendall in this connection, must still be accepted as our most reliable guide.

## REPORT OF CASE OF DOUBLE UTERUS WITH PREGNANCY OF EACH\*

W. M. ROWLETT, M. D.,  
Tampa, Florida.

Bicornate or double uterus is not so rare, though double uterus, with gestation occurring in both horns is rather an unusual condition. The case that I wish to report today is still more unusual, from the fact that the difference in the weight and development of the two feti shows that conception in one horn must have occurred six weeks or two months prior to conception in the other horn; a condition known as superfetation.

No doubt many cases of bicornate uterus escape our detection, the diagnosis never being made unless pregnancy takes place, or a laparotomy performed. This particular case seemed to me to be of sufficient interest to justify my reporting.

Mrs. R. G. W., white, thirty-six years of age; menstruation has always been rather prolonged and profuse. Has had three normal confinements and one miscarriage at three months. Had a laparotomy performed by Dr. J. S. Helms two years previously, at which time the double uterus was discovered. She was admitted to Bayside Hospital on March 18, 1923, complaining of severe nausea and vomiting and a prolonged and profuse menstruation. Upon physical examination, I found a large, irregular, bifurcated tumor in the lower abdomen, which I took for a pregnancy of about four months' duration. Knowing that my patient possessed a double uterus, I decided that the other half of the tumor was an unpregnated horn that had sympathetically become enlarged, thus demonstrating the unusual condition to several nurses who were present.

The vaginal examination showed a good perineum, cervix to be rather large, soft and somewhat bluish in color. Bimanual examination divulged two distinct masses.

After all efforts to relieve the nausea had failed, and the patient had grown progressively weaker, on March 30th, under gas-oxygen anesthesia, I endeavored to bring on labor by dilating

the cervix and introducing a catheter into the left horn of the uterus, that side being the larger. The cervix bifurcated about one inch within the external os.

Three days later, my patient gave birth to a male baby that weighed three pounds and four ounces, the membrane being expelled ten minutes later. To my surprise, the lesser horn of the uterus had not diminished and for the first time I suspected a double pregnancy. Two hours later she was seized with violent uterine contraction, and a vaginal examination revealed an unruptured membrane protruding from the cervix. Further exploration divulged the fact that this membrane came from the horn in which we had not suspected pregnancy. A few minutes later she delivered another male fetus weighing two pounds and three ounces. The patient made an uninterrupted recovery and was discharged fourteen days later.

From a review of the literature on pregnancy in double uteri, I find the proportion of twins is distinctly greater than in cases of single uterus. Thus I am of the opinion that many of our cases of twins are born of double uterus which go undiscovered.

The two outstanding features of this case were:

First—The comparative freedom from nausea with the first three pregnancies, contrasted with the pernicious vomiting with the twins.

Second—That conception occurred in separate horns at different times.

## DISCUSSION

*Dr. F. J. Waas, Jacksonville:*

I am sorry that I did not hear all of this paper. It is a very interesting subject.

The question of bicornate pregnancy is one of diagnosis. We are not always able to make a definite diagnosis in this condition. Many cases of bicornate pregnancies are diagnosed at time of operation for other conditions. I recall very vividly to my mind a case that had been referred with a diagnosis of perforated uterus, the case four days prior to coming under my observation, had undergone a curettage. She developed symptoms of sepsis and was sent to St. Luke's Hospital and referred to me for operation.

Upon examination I found a mass in the cul de sac. I immediately suspected a perforated uterus, operated and, much to my surprise, found a bicornate uterus with a pregnancy in one side and the other side apparently empty. I decided the best thing to do was a hysterectomy. Upon examining the specimen after removal, I found

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg, May 19-20, 1925.

two separate cavities in the uterus, one side empty and the other side pregnant. I felt at the time that the procedure resorted to was absolutely justifiable, as I was sure we were dealing with a septic uterus. Am very happy to say that this patient made a very uneventful recovery.

The X-ray must not be lost sight of as an aid to our diagnosis in suspected bicornate pregnancies.

Regarding intervention, don't feel that it is always necessary to terminate this variety of pregnancy, often Nature will take care of it and many times they will go on to full term and be delivered of twins. I am rather hesitant about advising emptying the uterus when we suspect a bicornate pregnancy.

*Dr. G. S. Edwards, Orlando:*

I am very much interested in Dr. Rowlett's paper. About fifteen years ago in Panama I had a case of pregnancy in the hospital with a double vagina and a double uterus. This case went to a successful termination without interference, but the separation between the two portions of the vagina was ruptured as you would suspect. Some time later I had a letter from my friend, Dr. Taylor in Colon, Panama, saying that this same patient had been delivered from the other cornu.

Anomalies are very interesting. Professor Ferris, my guide in anatomy, became so interested in them that he began making a record of all found in the dissecting room. He found so many that I think his work was never published.

To me it is a source of surprise that most of us express wonder when we discover an abnormality, when really we should be amazed at the fact that so many of us develop true to type. When you stop and think that we start from a single cell of undifferentiated protoplasmic matter and develop by means of a subdivision of cells which is more rapid than the subdivision of Florida real estate, is it any wonder that occasionally we find a case not true to type? There are three layers, the ectoderm, mesoderm, and entoderm, and these subdivide again and again rapidly, and soon new cells appear and specialize or develop special functions, and still subdivision continues. You have the Müller duct coming down each side and, strange as it may seem, these two parts contract and you have your one uterus and one vagina. I think it is absolutely marvelous that we can develop so true to type.

May I digress and say that it seems to me when we consider the one nucleus that we de-

velop from, just a single cell, that it is no wonder that we occasionally have a displacement or poorly developed or poorly nourished cell and some irritation comes along and we develop cancer. I think it is not strange at all.

*Dr. W. M. Rowlett, Tampa:*

I have no further remarks to make.

## DACTYLOMEGALY

### A BILATERAL AFFECTION. THE ONLY CASE REPORTED

R. R. KILLINGER, A.B., M.D.,  
Jacksonville, Florida.

Case Report: C. S., 33, colored. Normal delivery. Breastfed. Usual diseases of childhood. No serious illness. No accidents until twenty-one when he wrenched neck backward, severely straining the muscles of the neck. The following day, on the left front part of neck, a tumor mass began to appear gradually through the day and in a day or two gained the size of an English walnut. This mass has never changed since that time and has never caused him any trouble.

Family History: Father, aged 80. In good health. Mother, aged 70. In good health. Two brothers died as small children; cause unknown. Sisters, two; alive and well. All members of the family normal. He has two children alive and well and normal. There is no history of any abnormal enlargement of any part of the body in his family on either his father's side or mother's side, as far as they can recall.

History of point of interest: Born with present deformity as it now exists with reference to digits involved, but they have grown as the rest of the body grew. No differences in heat and cold sensations have been noticed as different from the other fingers. Tactile sensations the same. Muscular power good. Has worked for the past fifteen years in different capacities about railroad shops. Has performed the work of a roundhouse fireman for six years in an entirely satisfactory manner. There have been no sudden gains or losses in weight at any time in his life. Sleeps well, appetite good, bowels regular, no urinary disturbances. Has been solicited many times by shows and carnivals to travel with them at fancy salaries, but prefers a good honest living.

Physical Examination: Weight 150 pounds. Five feet nine inches tall. Scalp negative. Hair normal in distribution and amount. Eyes, pupils equal and react to direct and consensual light. Sclera clear. Ears normal in size and normal to auroscopy. Nose negative. Mouth: teeth, sev-

eral crowns, otherwise toilet of mouth excellent. Pharynx, negative. Measurements of skull, fronto-occipital 47.30 cm. Occipitomenal 57.2 cm. Type of skull, prognathic as expected in the Ethiopian. Neck, no tracheal tug. The left lobe of the thyroid is moderately enlarged to about the size of an English walnut. Chest, inspiration 77 cm., expiration 70.4 cm., waist 66 cm. On percussion and auscultation the lungs are clear everywhere. Heart, P. M. I. in fifth is inside the nipple line. On auscultation all heart sounds are clear and regular. The aortic second is greater than the pulmonic second. The blood pressure (Baumanometer) 122/80 on an average in ten readings. The pulses are regular and equal. No thickening of the blood vessel walls anywhere noted. Abdomen is soft, flat, no masses, no points of tenderness. The liver and spleen are not enlarged.

Genito-Urinary: Distribution of the pubic hair normal. Penis normal in size; no evidence of scars anywhere. No venereal history. Scrotum and testicles normal in size.

Lower Limbs: Normal in size everywhere. Bones and joints normal everywhere except fingers involved. Reflexes: No exaggeration anywhere. Skin: Soft, moist and flexible.

Measurements of Arms, Hands and Fingers: From elbows to tips of longest fingers, 72.6 cm.

From elbows to hand, 30.8 cm. The wrists are 17.5 cm. in circumference. From the wrists to the patella measures 33 cm. As an example, the right thumb measures 15.5 cm. from wrist to tip. The terminal phalanx on this member measures 11 cm. in circumference. The nail is 2.75 cm. by 2.2 cm. Both indices and middle fingers are turned mesially to permit a partial flexion of the fingers.

These measurements show there is nothing to be confused here with acromegaly, for the normal fingers are of like size on comparison with another negro of like weight and size.

Laboratory: Urine on two examinations did not show any pus, albumin, sugar or casts. Normal specific gravity, acid reaction.

The blood examination was negative for typhoid, malaria, and two Wassermann reports show negative on both antigens. The smear showed a normal count and no abnormal cells either in size or, on staining, no filaria found. The sputum was negative for tuberculosis on two examinations. Feces negative for parasites.

Rontgenological report by Drs. Cunningham and Shaw is as follows: "There is marked enlargement of the fingers both in length and diameter, on the left hand, the thumb and index fingers being involved. On the right hand a similar symmetrical hypertrophy, but only involving the



Fig. No. 1—C. S., X-ray Study of Both Hands.



thumb and index finger. The general appearance of these hypertrophied bones is that of a fairly normal structure except for some thickening of the periosteum near their necks. There is also slight irregularity of the joint outlines. Study of the head in a lateral view with specific reference to the sella shows an essentially normal appearance."

\* \* \* \* \*

Dactylomegaly is a rare developmental abnormality and the case here reported appears unique in that no record in literature is found of a bilateral affection.

In his encyclopedia, M. Polaillon was only able to find forty-three cases in literature (1897). His accounts are the most complete available on the subject, and until the recent advances in our studies of the endocrines not much has been done on the subject we are discussing, although much has been added to our knowledge of the functions of the hypophysis which is probably largely concerned. Polaillon states the condition to occur most frequently in males. There is no history of heredity and the middle and index fingers are most commonly involved. Only one case was hereditary for several generations. He further states that it is rare for only one finger to be affected. In some cases the hand or even half the body may be affected. He furthermore points out that two different conditions must be distinguished. In some cases the enlargement being due to hypertrophy of both bone and soft tissues, in other cases elephantiasis of soft parts only.

In casting about for a reasonable explanation of this rare phenomenon, investigators have been unable to present any clear, collected views on the causation. Perhaps Sir G. M. Humphrey gives us the best explanation. "The affection consists in an overgrowth of the tissues of the part, bones, ligaments, tendons, skin and more particularly of the fat and connective tissue; these tissues usually presenting their normal characters. The overgrowth continues to proceed after birth, often at a rate exceeding that of the rest of the body, and so to call for a removal of the part. The hands and feet are about equally liable, and the digits on the radial and tibial sides more than the others. In some cases the overgrowth shows a tendency to spread, more particularly along the sole. Now and then it is symmetrical, and occasionally it is associated with fatty growths in other parts. Reference is made to congenital overgrowths of like nature in lips, tongue and face; and an analogy is drawn between these examples of intra-uterine insubordination to the laws of development and growth, and the growths or tumors of later life, all or nearly all of which, simple and malignant, are referable to an abnormal overgrowth of the normally existing tissues rather than to a starting into activity of latent embryonic germs."

T. S. K. Morton noted in two amputations of fingers that the parts were exceedingly vascular and a number of catgut ligatures were required to control hemorrhage. Another case he reported had a constriction below the elbow on the af-



Fig. No. 2—C. S., Dorsal Photograph of Both Hands.

fect side, while below this there were many nodules and a condition of cavernous angioma affecting the fingers. However, under elastic pressure and constant application of 10% ichthyol in lanolin the condition was practically cured.

On the other hand, E. Tachard amputated a right ring finger in congenital dactylomegaly, made a histological study and concluded that the "collateral vessels and nerves were normal, the periosteum and bone normal and healthy, and that the integrity of the arteries and veins showed that they were not concerned in the process."

Morton observes that the metacarpophalangeal joints are practically normal. The interdigital joints are loose and permit of lateral motion, flexion of not more than half the normal extent possible. He attributes this to defective articulating surfaces of the interphalangeal joints as well as defective ligaments.

All agree that tuberculosis and syphilis are not concerned, that the condition is not hereditary. That the middle and index fingers are most commonly involved, and that it is a condition found most frequently in males. Several observers have had to amputate the affected digits account their being cumbersome and interfering with the movements of the rest of the hand in work. No one has offered a hypothesis of the causation. Most agree that it is congenital in origin.

Keith thinks there is an internal secretion from the hypophysis which sensitizes tissues to respond to natural stimuli of growth with increased vigor and energy. An extract of the hypophysis has

yielded a substance called tethelin which is supposed to have this specific effect on growth, but not much has been done with it clinically.

Blumer, in his most recent work, sums up the physiology of the pituitary as still confused and it seems unlikely that only a single secretory principle is produced either by the anterior or posterior parts of the gland.

Differential Diagnosis: Our case here presented cannot be confused with acromegaly, as it has been definitely shown that hypertrophy of the hypophysis is the rule in acromegaly. Laboratory findings substantiate this statement and exclude Froelich's disease, as no disturbance of the internal secretions can be demonstrated here. In myxedema there is no bony enlargement.

Marie's disease or hypertrophic pulmonary osteoarthropathy is excluded because of the normal findings on examination of the lungs.

Tuberculosis and syphilis are both excluded because of clinical and laboratory findings and the duration of the condition.

Osetitis deformans or Paget's disease causes a thickening of the cranial part of skull and involves the bones of the arms, forearms, thighs and legs rather than the hands and feet.

Syringomyelia is excluded as here we have no dissociated sensory disturbances, altered reflexes nor muscular atrophy.

Conclusion: The case here reported is the first description in the literature of a bilateral dactylomegaly.

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Fig. No. 3—C. S., Palmar Photograph of Both Hands.

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### ABRASIONS\*

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Kissimmee, Florida.

Of all injuries to the human body, abrasions may be considered the simplest. They are always superficial and may be examined with the simplest of means. They are always accessible for direct treatment, which would indicate that such injuries are not of such importance as to be the basis for discussion. Yet these simplest of injuries are the basis of nearly all surgical conditions of the soft tissues and should not be passed lightly by.

Abrasions may be so small in size as to be invisible to the naked eye, or they may be so large as to include a large portion of the body surface. Again, they may be so superficial as to include only the outer cells of the epithelium, or they may extend into the deeper tissues, in which case they may result in ugly scars. It is well for the surgeon to note the size and depth of each abrasion when making out his report lest old scars may be brought into the case later and be the basis for litigation.

Abrasions are most liable to occur on the most prominent parts of the body. The face, shoulders, elbows, knees, ankles and crests of the ilia are most liable to abrasions, but no part of the body is immune. The location of the abrasion has much to do with its importance to the surgeon. Abrasions about the head require more care to cleanse and dress on account of the hair and we cannot feel entirely safe without having

cut the hair away from the injured part before applying the dressing. These injuries about the head, however, heal readily on account of the very ample blood supply of the parts. Absorption here is more active and it is all the more necessary to guard against infection. Abrasions about the face are important for several reasons. If the abrasion should be deep, it becomes necessary to use every means at our command to avoid an extensive scar, for scars on the face are very productive of litigation, and may be justly so in some cases, for no one is willing to have his features marred if it can be avoided. Another important point to be observed in abrasions of the face is the discoloration from stains or foreign substances. If the abrasion is caused by being dragged against some green plant, there may be sufficient tannic acid or other organic substance deposited in the wound to discolor the tissues permanently. The author had a case of this kind result from some abrasions caused by being thrown against green palmetto stubbles. The color has remained permanent through about eighteen years. A similar condition might result from cankered axle-grease, but the iron and grease are usually so irritating that they will slough out before the healing process is complete. Abrasions about the tibia require special attention on account of the very poor blood supply in this part of the body. It is here that we are so liable to have a sub-acute or chronic condition result. Most of us who have been serving many years will remember some case of a simple abrasion which gave us much thought and care before it was healed. It is well, when treating abrasions of this part, to note carefully all old scars and varicose veins. The general health of the patient may well be noted, too. Abrasions about the openings of the body require special care on account of their position. Certainly we cannot use strong disinfectants about the eye lest we injure that organ more than we relieve the abrasion. About the mouth, abrasions may be difficult to treat on account of the dangers of poisoning, and, if such injuries become infected, they are hard to control on account of the looseness of the tissues and the near impossibility of keeping the parts at perfect rest. Abrasions about the anus or genitalia are hard to treat on account of the frequent exposure to infection. These should be dressed more frequently in order to obstruct this danger.

If abrasions could be treated without any com-

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plications, they would lose their importance in surgery, but the various complicating conditions give abrasions an importance among the first in surgery. We have already referred to the resulting scars and discolorations which should ever keep the surgeon on his guard when treating these minor injuries about the face and head. But the one most important complication of all abrasions is infection. An abrasion, be it ever so small, is the gateway for the entrance of bacteria which sometimes result in death even under the most careful scientific treatment. Only too well do we remember the death of our President's son from a simple abrasion on his heel. It is through abrasions that we have the beginning of pus infections, erysipelas, tetanus, anthrax, syphilis and many other diseases which may be both painful and in many cases even fatal. The results in treatment of abrasions may be very much varied on account of the constitutional condition of the patient. Varicose veins may retard healing so much that we may have a varicose ulcer result from the simplest abrasion. In cases of diabetes mellitus, a diabetic ulcer may have its beginning from one of these simple abrasions and be the basis for a much larger claim from our company than the injury would justify. Syphilitic ulcers must have a beginning and one of these simple abrasions is an easy beginning for a syphilitic ulcer. Depleted tubercular conditions render the tissues slow to heal and may be the cause of a chronic ulcer resulting from a simple abrasion. Even the oriental sore of the eastern countries might have its infection enter through a simple abrasion and be the basis for much litigation. In all these cases, the railroad company might be held responsible for the most serious results due to some other factor but having their beginning in a simple abrasion.

At first thought it would seem that the treatment for abrasions is so simple that any tyro should be amply prepared to care for any and all cases without even an effort to use his mentality, but this is far from true. While we all know that most cases heal readily without any special attention, we all know, too, that some of these cases result fatally, even with the most careful scientific treatment. To avoid such results and the criticism that may come from neglect, it behooves us to treat each case as if it were to be the fatal one. For this purpose it is well for the surgeon to carry a bottle of disinfectant in his emergency case. With this and a few cotton sponges he may easily cleanse an abrasion,

and, with a sterile gauze sponge and some adhesive tape, a protective dressing may be put in place till further developments may be determined. As indicated above, all stained tissue should be removed in cases of abrasion of the face to prevent tattoo, or colored scars. All particles of grit and other foreign bodies should be carefully removed to prevent abscessing from the irritation of these foreign bodies and the infection that they carry. But this simple treatment may not suffice. Most of us have learned to our humiliation that other remedies must be brought into action. When a simple abrasion progresses in the face of our treatment, from a simple injury clean and well dressed to an ugly ulcer, we begin to investigate for other causes. Perhaps there may be varicose veins which have passed unobserved, in which case we must apply the required support for the veins before we can get good results for our treatment. One of the most difficult conditions to treat is the resulting ulcer due to diabetes mellitus. Now that we have insulin, it is possible to relieve the diabetes in those cases where the patient yields to our control, but many of these cases are not willing to yield to such aggressive treatment for a simple ulcer, and it is sometimes impossible to cure the ulcer without first relieving the diabetes. As to tubercular and other depleted constitutional conditions, we all know how unsatisfactory our treatment is. The constitutional condition must be treated in conjunction with the local treatment. A matter of importance for us to remember is that people differ very much as to their susceptibility to drugs. In many cases tincture of iodine is par excellence the best remedy to disinfect abrasions, but some people are very susceptible to iodine and a severe dermatitis may result from a single application of this drug, which may complicate the condition and delay healing. Each one is a law unto himself as to this susceptibility and it is well to keep this in mind.

As a matter of prophylaxis, it is well to give immunizing doses of anti-tetanic serum in those cases where dirt has entered the wound.

It is hard to establish a routine treatment for abrasions on account of the variations of the size of the wounds and the circumstances under which treatment is attempted. The author has found it convenient to carry in his emergency bag a pint bottle of a glycerinized solution of carbolic acid and boric acid combined. With this solution and a roll of absorbent cotton, it is easy to cleanse most wounds, and, after cleansing, the wound may be easily dressed and pro-

tected by a gauze sponge saturated in this same solution. This solution has no special advantage over other good disinfectants except that it is more stable than some of them. If the abrasion is small, the patient may be dismissed with this dressing, but, if the abrasion is extensive and deep, it may be necessary to put the patient to bed and repeat the dressing at subsequent times until nature can restore the damaged tissue. It is only a few months since the author had a case of extensive abrasion, covering an area of about a hundred square inches and extending through the dermis into the areolar tissue. This was caused by being caught on a revolving shaft which ground the skin off the inner side of the thigh and at the same time burned the tissues by its rapid revolutions. This abrasion had to be treated more as we would treat a burn and required several weeks to heal. It is well to avoid the common method of the laity in treating abrasions with ointments since these only make an excellent lodging place for the bacteria of infection and increase the probability of infection. A dry dressing of calomel and bismuth is satisfactory in many abrasions where only the outer skin is injured, but it does not protect sufficiently for the deeper and more extensive abrasions. Dakin's solution is used by many with most excellent results, but it is not so stable as is needed to carry in an emergency bag. If the case is of such magnitude as to need after-treatment, I know of nothing more satisfactory than Dakin's solution.

In recapitulation I would say that the important points in treating abrasions are early treatment, thorough cleansing to avoid infection and discoloration and careful adaptation of the remaining fragments of skin to avoid disfiguring scars, while the surgeon must keep ever in mind the constitutional condition of the patient and institute such means of treatment as will overcome constitutional conditions which are liable to complicate and prolong the condition, and don't forget to note any old scars that may be seen in the vicinity of an injury.

#### POSTENCEPHALITIC SYNDROME, POTENT CONJUGATE UPWARD MOVEMENT OF THE EYES WITH TEMPORARY FIXATION

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Miami, Florida.

Current literature embodies several references to this syndrome in which the patients invariably complain that their eyes turn up and inability to

get them down, in which condition the ophthalmologists are unable to determine any objective findings which could account for the difficulty and are perhaps inclined to regard it as an hysterical manifestation. A recent article by Leslie B. Hohman, of the Phipps Clinic, Baltimore, in the *Journal of the American Medical Association*, May 16, 1925, recites three cases. A review of the literature seems to point in the direction in all of these cases of a postencephalitic Parkinsonian syndrome. The writer's case, now under treatment, is quite characteristic of the three cases reported by Doctor Hohman, this case showing a typical Parkinsonian masked face, disturbance in gait, and muscular coordination, complains of her eyes being caught up and fixed and inability to get them down. This patient seems to have suffered epidemic encephalitis about five years ago and the symptoms have persisted more or less since. While this particular symptom has not disappeared by any means during the time of observation, it is perhaps a little less frequent and explanation has rendered the patient a little more adjustable to the condition. The patient's nutritional condition is poor, although she consumes an adequate amount of food, having a good appetite most of the time. The patient's height is four feet eleven inches, and her weight is eighty pounds. Since this attack of encephalitis, the patient has had a right-sided thyrolobectomy and has given birth to a very healthy looking child now about two years of age. A diagnosis of encephalitis was not made at the time of the patient's confinement in the hospital; the hospital chart diagnosis is influenza. The patient insisted that she would go to sleep and could not wake up. She would fall asleep while talking. The patient has also, at this time, bilateral horizontal nystagmus, irregular in rhythm. The patient is unable to close the eyes and hold them closed. Conjunctiva reflexes are present, but the patient is unable to wrinkle the forehead. The tongue protrudes in a straight line with slight marginal tremor on the left side.

From our present knowledge of the neuropathology of this residual it would appear that a more or less active inflammatory reaction persists for a long time after the onset of the disease and it is quite possible that the eye muscle spasms are evidence of a persisting inflammatory focus in the mid-brain. The symptom without too pronounced other evidence of a postencephalitic condition is often quite thoroughly overlooked or ignored, one being impressed that the origin of



the difficulty is psychogenetic and belongs to that class of obsessive activities like tics and habit spasms.

## STRICTURES OF THE URETER\*

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Pensacola, Florida.

I would like to bring to your attention the question of strictures of the ureter, a condition which in my opinion is overlooked more than any other at the present time. Many appendices, ovaries and tubes have been sacrificed when a thorough urological examination would have disclosed a very different condition.

### *Etiology.*

The etiology of this condition is as follows:

First—Focal infections, particularly those of the nose and throat, are a vital factor in the production of these conditions. Infected tonsils have been found to be the most common infecting agent.

Second—Acute inflammatory conditions of the female pelvis and infections in the broad ligament area.

Third—The passage of sharp-edged calculi and calculi that become impacted in the ureter.

Fourth—The acute severe pyelites and pyonephroses extending down the ureter by continuity producing damage to the upper portion of the ureter.

Fifth—A small number of cases may be the result of difficult labor and forceps delivery.

### *Location.*

In a series of one hundred cases in the female I have found the larger percentage of strictures to be in the lower portion of the ureter extending from the ureter orifice in the bladder to the level of the pelvic rim, in the broad ligament area.

The next most common site was at the renal pelvis junction with the ureter.

The majority of the cases show a bilateral involvement, although the symptoms may be confined to one side.

The condition is to be found at all ages, but is most commonly found between the ages of thirty and forty. This range, however, I believe will be changed in the future when the profession as a whole becomes more familiar with the condition. I base this prediction upon the fact that

the cases I have seen gave a history that extended back for a number of years. We will no doubt in the future find more cases in children and young adults.

About 30 per cent of the cases showed an accompanying infection of the renal pelvis, which is the result of prolonged damming back of the urinary stream producing a renal congestion which becomes a fertile field for infection.

The common infecting organisms being the colon bacillus, the staphylococcus and the pyocyaneus. Also about 30 per cent of these cases show accompanying calculi. The longer the condition exists the greater the liability to stone formation. Where the condition is the result of a laceration by a calculi one can readily see the vicious circle that may result.

### *Symptoms.*

These vary with the age and severity of the condition. It may exist for a long period of time with little more than an occasional frequency which may be accompanied by tenderness over the site of the stricture, or it may be that typical renal colic will be the first symptom. Pain of a dull aching character in the renal area which at times may become acute and typical of renal colic is more or less a constant complaint. The pain is often radiated to the hip and down the inner and anterior aspect of the thigh of the affected side. Tenderness at the site of the lesion is nearly always present, particularly in those cases of long standing. Frequency is usually present or can be obtained in the past history. Hematuria occurs in those cases with severe infection. Neurasthenic states are very frequent in the female. All symptoms are exaggerated by acute intercurrent infections, particularly those of the nose and throat.

Diagnosis: This as a rule is not difficult and is made from the physical examination, history and urological examination with the passage of the wax bulb catheter, or by X-ray after the injection of some pyelographic medium, which shows the constriction with the dilated ureter above.

### *Treatment.*

Consists of the gradual dilation of the structure with increasing sized catheters and bougies. Any infection present may or may not demand treatment, depending upon the severity. Mild infections require practically nothing as the re-establishment of drainage will be all that is necessary. Cases with severe infection require lavage with boric solution and the instillation of sil-

\*Read before the Escambia County Medical Society, May 26, 1925.

ver nitrate solution. The results of the treatment in these cases is often spectacular, particularly in the neurasthenic woman.

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PROCEEDINGS DUVAL COUNTY HOSPITAL STAFF SCIENTIFIC MEETING,  
CONDUCTED BY DR. STANLEY  
ERWIN, CARDIOLOGIST,  
MAY 28, 1925.

*Dr. Stanley Erwin:*

It is difficult to diagnose aneurysm of the thoracic aorta, especially of the arch, unless the aneurysm is in its terminal condition, and exerts mediastinal pressure upwards and downwards. Pressure causes the classical aneurysm symptoms of pain, cough, difference in blood pressure and pulsation over upper part of sternum. It is also difficult, in fact, almost impossible to differentiate thoracic aneurysm, in its first stage, from syphilis of the heart showing myoendocardial pathology.

I am presenting two patients, one with an aneurysm of the thoracic aorta, and one with syphilitic myoendocarditis, showing aortic insufficiency with secondary mitral insufficiency and cardiac decompensation.

(Patients are brought in and arranged on tables.)

*Dr. Erwin continues:*

These patients have exactly the same history, major signs and symptoms; that is, each has the usual venereal liability, alcoholic indulgents, hard physical stress, exposure to infection seen in the negro. Each has an enlargement of the cardiac base, a bruit, venous pulse with enlarged throbbing veins. Both are decompensated; neither has any pressure symptoms, that is, no pain, cough or tracheitis. There is no difference in the pulse volumes. Both have aortic and mitral murmurs; both give the appearance of aneurysmal dilatation of the aorta, yet when studied a differential diagnosis is possible without roentgenological aid.

We will now examine the older man. This man is about fifty years old. You see he has a small pulsating mass in his neck. This can just be seen above his clavicle and sternum. You can easily feel this mass under the clavicle and in the episternal notch. It shows great pulsation. Each vessel can be outlined. The hard mass in the episternal notch is the aortic arch; that under the clavicle is the right subclavian, pushed up by the innominate. You can follow out the right subclavian as far as the inner one-third of the clavicle. All vessels are markedly sclerosed, es-

pecially the temporals and radials. You will observe his arms. Even the veins can be picked up separately. Percussion shows a large hypertrophic dilatation of the left ventricle and auricle; also a mass above the heart. His cardiac measurements are: Left, 13 cm. at ensiform; right,  $5\frac{3}{4}$  cm., making his apex line  $18\frac{3}{4}$  cm. His base measurements are:  $8\frac{1}{2}$  cm. at third rib, and  $10\frac{1}{2}$  cm. at second rib and interspace. This increased measurement above the heart clearly shows that this man has an extra cardiac mass. He has no undue pulsation over the heart area except to the right of the sternum. Here he has a shock and thrill transmitted upward. He has no recognizable murmur except a systolic blow at the apex transmitted to the left. Over the whole heart area, except the apex, there is a bruit. His blood Wassermann is negative; blood shows nothing unusual; urine, some evidence of nephritis.

We will now examine the young man. This man is about twenty-seven years old. He, also, has a big neck, with marked throbbing, but if you feel his neck it is different. It is softer; no distinct mass can be felt. You cannot differentiate any vessel except the jugular. His throbbing is of the jugular and carotid. This is due to the venous pulse, and the usual cardigan type of arterial pulse seen in aortic insufficiency. He has no episternal mass or pulsation except on deep pressure. His arteries can only be slightly felt. He has no sclerosis. His entire heart area shows markedly increased pulsations, shocks and thrills. He has a bruit over the area of the upper one-third of the sternum. There is a diastolic murmur beginning at the third interspace to the right of the sternum, and transmitted upwards. This is evidently an aortic insufficiency. There is a systolic murmur at the apex transmitted to the left. This murmur merges with another systolic murmur over the ensiform, which is transmitted upwards along the right border of the sternum. This is tricuspid and mitral insufficiency. His heart measurements are: apex, total 18 cm.; base at third rib, 12 cm., and at second interspace,  $9\frac{1}{2}$  cm. You will see the difference in the base findings between this and the first patient.

The pathology of these enormous cardiac dilatations seen in aortic and mitral lesions is, first, a hypertrophy of the left ventricle, aortic leak, relative mitral insufficiency, dilation of the left auricle, loss of compensation, hyperemia of the lungs, dilatation of the right auricle, then when the tricuspid goes, dilatation of the right ven-

tricle. The left-right auricular dilatation plus the cardigan type of pulse, simulates aneurysm. This is well illustrated in this patient. X-ray examination has confirmed the diagnosis in each of these patients.

You will also notice the enlargement of the liver seen in the second patient. He has syphilitic colangitis. This is of interest to you surgeons.

*Dr. John E. Boyd, President of the Staff, in the Chair:*

These cases are of interest. Those of you wishing to examine the patients come forward and do so.

(Patients are examined by members of the staff.)

*Dr. Boyd:*

The discussion will be opened by Dr. McGinnis.

*Dr. McGinnis, Chief of Medical Service:*

These men have improved. They are much better than when admitted. They are still decompensated. It is interesting to note that the old man has no recurrent laryngeal disturbance. He has no cough. Undoubtedly he will have a rupture of his aneurysm. All that we can do for him is to watch his condition and take care of him.

*Dr. Herman Harris, Associate Medicine:*

These are certainly two very interesting cases, and Dr. Erwin has very clearly brought out the sometimes difficult differential diagnosis.

Even with a repeated negative blood Wassermann, and no evidence in the history of past syphilitic inoculation or symptoms, it would seem advisable to administer antiluetic treatment, for certainly the vast majority of aneurysm of the aorta are syphilitic. It does not do to put too much confidence in the result of a deviated complement.

*Dr. Erwin:*

I have another case, so we must expedite.

*Dr. Boyd:*

Dr. Erwin will close the discussion.

*Dr. Erwin:*

Dr. DaVilla (medical resident) has prepared a chart showing the relative anatomical relations of the tissues in the neck, and of the heart and blood vessels. You will see the effect of pressure caused by aneurysm of the various divisions of the thoracic aorta, and also see how dilatation

of the auricle can simulate aneurysm. It is of interest to know that the X-ray shows the aneurysm has deflected the old man's trachea to the right. You would expect a tracheitis. Massive dilatation of the auricles is supposed to cause tracheal deflection, but none is observed in the young man. We are giving both patients anti-syphilitic treatment, although the aneurysm is supposed to be arterio-sclerotic in cause.

*Dr. Erwin continues:*

The next patient has had many classical diagnoses. These are all terminal, and do not cover the primary cause of her illness. We do not know what is the matter with her. She is on this service because of the extreme cardiac decompensation, and is shown to you for discussion.

(Patient is brought in; is an emaciated negro woman, with a rather prominent abdomen.)

*Dr. Erwin, continuing:*

Dr. DaVilla will read the history and physical findings on admission.

*Dr. DaVilla, reading from chart:*

Tunsil, Lillie Bell, age 24; colored; married.

Family history: Has no bearing on present condition.

Chief complaint: Shortness of breath and swelling of abdomen.

Personal history: Usual disorders of childhood, smallpox and influenza before marriage. Since marriage has never been ill until three weeks after the birth of her second child seven months ago. Then she noticed that her feet and legs were swollen at bed time. This swelling gradually increased, extending to her thighs and abdomen. She developed shortness of breath, pain in chest and abdomen with an occasional cough and expectoration. She states that she thought she had fever. There is no history of tuberculosis, syphilis, vaginal infection, rheumatism or other diseases. There is no history of alcoholism, or drug addiction. She is not constipated, and has never had diarrhea. There is no history of injury. Her obstetrical history is the usual found in the negro, delivery was not instrumental.

#### *Physical Findings.*

General Appearance: That of a colored female aged 25 years, well developed and nourished. There is evidence of jaundice. Patient is sitting up in bed in apparent distress, complaining of shortness of breath and presenting abdominal enlargement. Apathetic, uninterested expression on face. Mentality and cooperation poor.



Eyes: Pupils round, regular and equal. React to light and distance. Ocular movements and tension normal. Conjunctivæ jaundiced.

Mouth: Mucous membrane, pale and shows small white patches. Tongue slightly coated. No fissures, protrudes in midline, no tremor.

Teeth well kept, no pyorrhea, slight caries, no dentistry, breath fetid.

Pharynx: Tonsils imbedded and fibrosed.

Neck: No glandular enlargements. Cervicals not palpable. No abnormal pulsations.

Chest: Alar in type; there is slight bulging of right superclavicular fossa as compared with left. There are some venous fibrillations over this region and close to the root of the neck. There is slight retraction of upper right chest. Respirations are shallow and slightly labored. Expansion somewhat limited in right upper chest. There is some impairment of resonance over right apex as compared to left.

Percussion note is a little hyperresonant below clavicle, anteriorly on the right as far down as fourth interspace. On left it is resonant down to third interspace where it becomes dull and then merges suddenly into a flat note. This flatness is obtained all over lower chest and entire axillary region on left.

Posteriorly there is resonance on both sides down to the eighth rib where it becomes dull on right and flat on left. Breath sounds are bronco-vesicular anteriorly over both sides except over lower left chest and left axilla where they are abolished. Posteriorly breath sounds are very distant and on left sides at level of angle of scapula they do not come through at all. Vocal resonance is somewhat diminished on left upper posteriorly and much diminished over left lower lung. There are no adventitious sounds.

Heart: There is no precordial bulging, there are superficial venous pulsations over left supra-clavicular fossa, at supra-sternal notch and at root of neck on right side.

There is a slight impulse at third interspace about 6 cm. from MSL. Apex beat cannot be located by inspection; PMI is at fifth interspace 9 cm. from MSL.

Left lateral limits of dullness  $11\frac{1}{2}$  cm. from MSL.; total base line  $17\frac{1}{2}$  cm.; width at third interspace 10 cm.

I am unable to determine accurately the left lateral limits of dullness of heart because of the extreme flatness of axillary region. I had to be guided by the resistance of the chest wall.

There are no murmurs, shocks or thrills.

The heart sounds over aortic region are distant, A 2 is accentuated, P 2 is split.

Blood pressure 135/85.

No pistol shots at femorals. Pulse at radials are synchronous. There is no water hammer pulse, but there seems to be an occasional retraction of the pulse wave at left radial.

Abdomen: Ovoid, uniformly distended. Walls are edematous. Umbilicus protrudes. There is a small umbilical hernia. Skin somewhat wrinkled. At its most superficial layer it is scaly and dry. There is no pain or tenderness on palpation. There is shifting dullness and fluctuation splash. No definite masses can be made out. Uterus not felt at all. There is tympany in front while patient is recumbent and dullness on the flanks. There is no distention of the superficial veins of abdomen. Liver can be vaguely felt about six fingers' breadth below costal margin. Spleen cannot be palpated.

Vaginal: There is no vaginal discharge, nor discharge on milking urethra. Vulvo-vaginal glands are not palpable. Cervix very small, bilaterally lacerated, and freely movable. No masses towards region of tubes. There is a cystic feeling imparted to the examiner on palpating anterior wall like that of a cystocele. No definite masses were felt towards posterior cul de sac. Perineum somewhat relaxed. Uterus could not be palpated.

Rectal: There is evidence of external hemorrhoids. A small, irregular, round, hard, movable mass is felt through anterior wall of rectum. It is tender to manipulation, suggesting a retrodisplaced uterus.

Extremities: There is considerable edema of the legs and thighs, with wrinkling of skin. No articular swelling.

Reflexes: KJ. feebly active and equal. Patellar and ankle clonus negative. Abdominal absent. Babinskies, Kernigs, Rombergs, Oppenheims, Gordons, negative.

N. M.: Slightly emaciated.

Glands: No general glandular enlargements. Anterior and posterior cervicles not palpable.

Skin: Dry, warm and inelastic.

*Dr. Erwin:*

The X-ray report of March 19, 1925, corroborates the physical findings in the chest, except the displacement of the heart to the right. This was considered dilatation of the right heart, due to back pressure in the lung. The left border of the heart was obscured by a flat note, from fluid in

the left pleura. Doctors Cunningham and Shaw have examined this patient twice. I will read both reports, the first on admission, the second after cardiac compensation had been established, and the fluid in the abdomen and chest removed by needle.

### *First Report.*

Date of Consultation: March 19, 1925.

Referred for study of chest and abdomen.

Study of this patient, both film and fluoroscopic, was executed with difficulty. The patient is holding a large protruding abdominal mass, probably an umbilical hernia, and is exceedingly dyspnoëic. The left chest appears to be largely filled up with either fluid or consolidated lung, probably fluid. The heart is probably displaced, slightly towards the right side. The right chest is also increased in density, especially in its lower border suggesting fluid in the right chest which is increasing in amount. A small portion of illuminated lung is noted in the upper left.

Stereoscopic films could not be secured due to the extreme dyspnoëa. No information could be obtained in the oblique views. One gets the impression of marked changes in both lungs, and apparently fluid.

### *Second Report.*

Examination: Referred for study of chest, heart and liver. Films No. 17590. Preliminary screen study of the chest and abdomen shows the heart displaced considerably towards the right, more of it being in the right chest than in the left. The right diaphragm appears negative, the left does not move. No lung markings are noted in the left lung field.

Screen study of the abdomen is negative except for a suggestion of a soft tissue mass extending down across the abdomen at the level of the umbilicus with rounded lower border arising somewhere in the region of the liver. This can be displaced easily on pressure and does not appear firm. The possibility of its being fluid cannot be eliminated.

Study of the stereoscopic films of the chest indicates the heart displaced towards the right, and in the left pleural cavity there appears a pneumohydrothorax, the left lung being collapsed and not aerated to any extent that can be noted on the films.

Study of the films covering the abdomen with special reference to the liver does not indicate the size of the liver. There is free fluid in the abdomen which prevents a satisfactory examination with the X-ray.

Dr. Boyd was called in consultation before the abdomen or chest was drained. This was necessary at this time in order to eliminate massive cyst of the abdomen.

*Dr. Boyd:*

This case presents an unusually interesting study from a diagnostic standpoint. The first time she was seen by me I was unable to make any examination of the abdomen on account of the enormous distention from fluid.

Dr. Broadbent drew off the fluid by means of trocar and canula. This left the abdominal wall very flabby and pendulous. The examination was now made without difficulty. I will read from my notes on consultation sheet:

Date of Consultation, March 17, 1925.

Examination: When I first saw the abdomen on the 16th it was so distended with fluid that I was unable to properly examine. Today, after tapping cavity, the belly wall is relaxed, but still pendulous. The liver is easily palpable, very much enlarged and very hard. It seems to me that I detect other masses in the cavity. Am unable to palpate spleen. The patient makes no complaint of localized tenderness.

Opinion: Several questions arise, among which are cirrhosis of liver, syphilis of liver, tuberculosis of liver and peritoneum. If the Wassermann is negative I would be inclined to the diagnosis of tuberculosis.

Recommendation: None surgically, except to keep abdominal cavity empty by repeated tapings.

I will also read the consultation notes made by Dr. Simpson, who is not present to discuss the case.

Date of Consultation, April 14, 1925.

Examination shows diastasis of recti; small umbilical hernia, distended abdomen, relaxed muscles; no rigidity, no palpable masses. Liver is only solid organ palpable. It is considerably enlarged, with sharp, hard border. There is the sensation of pea-sized nodules on border and anterior surface of liver (Hobnail?).

Opinion: That this is a case of cirrhosis of the liver of the hobnail type.

Recommendation: No surgical treatment recommended.

This case also had quite a large serous exudate in the left pleural cavity, none in right. One of the interesting features is that there never was any recurrence of the ascites after the one tapping. To my mind this fact rather discredits the diagnosis of cirrhosis of the liver.

As I feel this abdomen tonight I am unable to find any masses referred to on consultation sheet. A correct diagnosis may never be made without an exploratory laparotomy. There was a time when I felt such a step might be advisable. At the present time I can see no justification for it.

This case is very much out of the ordinary. The abdomen should be examined by all the surgeons present. Personally, I now feel that the most plausible diagnosis was an acute hepatitis due to an active infection.

*Dr. Erwin, continuing:*

Her temperature has varied from 99° to 103°. At the present time she has no increased temperature. Urinary findings are normal. Renal function test is normal. There is a negative Wassermann after repeated examinations. Sputa examination after numerous tests is negative for tuberculosis. Her blood studies has shown persistent leukocytosis with marked increased poly counts. Blood sugar and urea are within the normal range.

You will observe her chest. It is flat. Respiration is limited over the left side. There is a hyperresonant note over the lower two-thirds of her left chest, both in front and behind. She has a left pneumothorax. Her right lung is now clear. You will remember from the history that she was admitted with a hypostatic pneumonia, and pleurisy with effusion. Whether this was primarily due to infection, or secondary to cardiac failure, is a pertinent question.

You can feel the apex impulse close to the sternum on the left. She has a distinct thrill over the apex, and transmitted up along the sternum. Her heart is displaced, that is pushed over to the right. She now has a mitral systolic murmur. This murmur was not recognizable until a few weeks ago. Her liver is still enlarged, but it is soft. There are no other masses. Some fluid is still in the abdomen. You can see the umbilical hernia. The impressions of the Medical Service was multiple small abscess of the liver, following infection from her last delivery.

Consultants have not agreed with this diagnosis. You may draw your own conclusions. Remember when you make your examination, she has been very sick.

*Dr. Boyd:*

Those who wish may come up and examine patient.

(Members of the Staff examine patient.)

*Dr. Boyd:*

The discussion is now open.

*Dr. Geo. Mitchell, Associate Tuberculosis:*

Primary pleuritic effusion and spontaneous pneumothorax are usually due to tuberculosis. I would say that the diagnosis was tuberculosis unless otherwise proved.

*Dr. Herman H. Harris, Associate in Medicine, in charge of Metabolic Diseases:*

The diagnosis of tubercular pleurisy depends on conditions found in the right lung. If the right lung seems to be clear on physical examination, and the X-ray findings are negative for tuberculosis, and if repeated sputa examinations are negative, I would say it is not tuberculous.

In a generalized infection of this type, the right lung would most probably be involved in the pathological process, if tuberculosis was the cause of the condition. Negative sputa examination over a prolonged period of time will usually, but not always, eliminate the diagnosis of tuberculosis.

Tubercular peritonitis causes a primary ascites, and is not associated with general edema, only as a terminal condition.

I would like to ask if it were possible for this pneumothorax to have developed from the needling of the chest?

*Dr. Robert McIver, Associate Surgeon in charge of Urology:*

The fluid from the pleura and abdomen should have been tested on a guinea pig. Was this done?

*Dr. Boyd:*

Dr. Erwin will close the discussion.

*Dr. Erwin:*

I have previously stated that the diagnosis of the Medical Service was multiple abscess of the liver, following primary focus of infection in the uterus from delivery. This theory is based on a possible blood stream infection with bacterial rests in the liver. The diagnosis is based on a careful consideration of the history and the blood finding, as well as physical condition.

This woman was never ill until three weeks after her second baby was born. Then she had evidence of infection characterized by edema. This infection progressed until she was totally disabled, and in danger of death. At all times she had a leukocytosis with increased poly. count. This increase of white cells is not compatible



with chronic infection, that is, tuberculosis or syphilis, unless there is a mixed infection. Neither syphilis nor tuberculosis cause leukocytosis or an increased poly. count. These diseases usually produce leukopenia and lymphocytosis, that is, an evidence of anemia, and there is always a history of previous infection or symptoms extending over a long period of time. The onset is not distinct or sudden, or the progress so general or rapid. The disease picture is never acute.

The negative blood and sputa findings are against tuberculosis or syphilis. If the condition was caused by a mixed infection the acute symptoms might subside, but the chronic condition, demonstrated by continued acute and enlargement of the liver and steadily advancing lung change, would continue.

I am going to read the laboratory findings. These extend over the period of her illness.

March 13—P. S. P., first hour, 10%; second hour, 35%. All other urinary findings normal.

March 25—Stool, negative for amoeba.

March 25—Fluid from the pleura and peritoneal cavities sent to the State Board of Health for guinea pig test. This report was returned at the usual interval of time, negative.

March 17—Hemoglobin, 80%; red cells, 4,500,000; white cells, 13,800; poly., 85%.

March 21—White cells, 18,400; poly., 90%.

March 23—White cells, 17,600; poly., 84%.

March 30—White cells, 16,800; poly., 80%.

The white count has varied constantly; the last count being on May 5th; red cells, 4,000,000; white cells, 30,000; poly., 90%.

All tests for tuberculosis were negative; all Wassermann tests were negative with both antigens.

I do not believe the above laboratory findings compatible with the chronic infection. Whether the diagnosis of multiple abscess of the liver made in the beginning of the case, or the present impression of acute hepatitis is correct, is unknown, for there will be no exploration.

I have insisted that this girl be operated. The Surgical Service has not agreed, and from the appearance of the girl now, they were right.

Dr. Harris asked about an accidental pneumothorax from drainage. This I cannot answer, but I do not believe the pneumothorax was accidentally acquired.

I wish to thank Dr. DaVilla for his earnest cooperation and assistance in preparing these patients.

### *Note by Editor.*

The aneurysm case presented died suddenly June 23rd from an apparent acute dilation of the heart. It is of interest to note in this case that he had had an occlusion of his left coronary artery. This condition had healed, and was doubtless responsible for his low blood pressure.

The narrowing of the abdominal aorta shown in the autopsy report is not unusual in aneurysmal cases.

We are indebted to Dr. Kirk, pathologist, for the following report:

*Excerpt from autopsy notes in the case of Sam Small (colored), dying at the Duval County Hospital June 23, 1925, and examined by autopsy the same day.*

Heart: The pericardium contains a greatly dilated heart, but shows no excess of fluid or evidence of inflammatory reaction. The right side of the heart is greatly dilated (300%); the left side of the heart hypertrophied and dilated about 200%. The bicuspid and mitral valves are relatively dilated (200%), but show no vegetations. The pulmonary valve is normal in appearance and the opening normal in size. The aortic opening is partly closed by thick calcareous deposits in the cusps and the ring is dilated somewhat, but the cusps on account of their rigidity narrow the real opening greatly. Both coronary arteries are sclerosed and tortuous and are typically "pipe-stem." The posterior coronary shows near its distal third an occlusion by a calcareous area or plaque about two millimeters long. The muscle tissues of the heart in this region appear poorly nourished.

Aorta: The ascending aorta and the aortic arch is dilated fusiformly (50%) to (100%) (fusiform aneurysm) exhibited occasional large plaques, but shows no evidence of rupture. The vessels from the arch are sclerosed but are not dilated in death. The abdominal aorta throughout is distinctly smaller than normal and near the bifurcation (2 inches proximal to it); there is a constriction of more than 50% the diameter of the vessel elsewhere. Many large plaques are found in this portion of the vessel and in both iliac vessels.

Kidney: Both kidneys are enlarged, red, firm, with cortex and medulla moderately diminished. No stone, or evidence of active inflammation found.

# The Journal of the Florida Medical Association

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DR. JOSEPH YATES PORTER, SR.

The reminiscences of Doctor Porter, relative to health work, covering a period of fifty years, will be published by THE JOURNAL as authorized by the Florida Medical Association at its annual meeting held at St. Petersburg, Florida, May 19-20, 1925, in serial form.

The first serial appears in this issue of THE JOURNAL. It will require seven issues to complete the narrative. We feel confident, however, that the interesting narration of events in the early days of sanitation and quarantine regulations, as depicted by Dr. Porter, will manifest keen interest and careful reading.

Dr. Porter, soon after graduating in medicine,

entered the Army service of the United States and was ordered to a camp in Texas on the border of Mexico. At this post of duty he met a young Captain of the Army, Dr. Wm. C. Gorgas. They here formed a close, loving and lifelasting friendship. Dr. Gorgas afterward became Surgeon General of the United States Army and a sanatarian of international reputation.

Dr. Porter, by advice of noted diagnosticians, resigned from the army and located at Key West, Florida. He early became interested and familiar with epidemic diseases, especially yellow fever. During the nineteenth century yellow fever was the principal epidemic and most dreaded disease introduced into Florida, particularly from Cuba.

Dr. Porter was elected State Health Officer and executive secretary by the first State Board of Health in 1889 and served in this capacity under succeeding boards until 1917. He not only organized the health work of the state in its various departments, directing and enlarging the departments to meet requiring conditions, but was appointed Sanitary Inspector of the state by the United States Marine Hospital Service—now the United States Public Health Service—the only position of the kind in the country. His duties in this position required supervision and inspection of the various quarantine stations of the state. The quarantine officers were appointees of the Government. As health officer he received a meager compensation.

Yellow fever was introduced into the state on three or four occasions after the establishment of the State Board of Health and was promptly eradicated. The last visitaion of this disease developed at Pensacola, Florida, brought from New Orleans in 1906. Dr. Porter moved his office force and laboratory facilities from Jacksonville to Pensacola to combat the situation, and by energetic, strenuous work closed the campaign against the disease prior to the advent of frost, an accomplishment unprecedented.

Dr. Porter became a member of the American Public Health Asociation in its infancy, was a faithful and consistent attendant of its meetings and contributed much to its scientific program. It has been observed that when he entered the assembly room at these annual meetings the entire organization, as one man, would rise to their feet in respect to his sanitary ability and in honor of his achievements. His discussion of sanitary and allied subjects was always listened to with great interest.



Dr. Porter is now nearing the sunset of life, being nearly four-score, and the physical infirmities of this period have handicapped him, but the mental vigor of his brain is acutely active and he speaks with clearness, conciseness and accuracy.

### ZINC STEARATE

The second report of the Committee on Accidents from Zinc Stearate Dusting Powders,\* appointed by the Board of Trustees of the American Medical Association, has recently been published. One hundred and thirty-one accidents from the inspiration of zinc stearate dusting powders by infants were reported to this committee. Of this number there were twenty-eight deaths. The total number of reported accidents probably does not in any way represent the number of cases occurring, for in every community these accidents are not an uncommon occurrence.

The committee in their effort to mitigate this danger have worked along two lines: (1) to obtain the cooperation of the manufacturers and distributors of zinc stearate powders; (2) to obtain representative opinions concerning the usefulness of zinc stearate in the nursery.

The representatives of numerous pharmaceutical houses have agreed to only dispense zinc stearate powders in a self-closing topped box. As to the therapeutic value, thirty-four inquiry letters were sent to representative pediatricians. Thirty-one believe that zinc stearate dusting powders have no advantage over other dusting powders, and that they considered them a hazard to infant life. Three feel that the powder has some therapeutic value.

The recommendations of the committee are as follows: That all manufacturers of zinc stearate powders for infants be requested to use a self-closing container of a type which does not lend itself to manipulation by an infant, and to place a uniform caution label on the container. That the use of zinc stearate as a dusting powder for infants be discouraged by the medical profession because of lack of therapeutic evidence of its value.

\*The complete report of the committee may be had by addressing the Committee on Zinc Stearate Dusting Powders, American Medical Association, 535 North Dearborn street, Chicago, Ill. Enclose a self-addressed stamped envelope.

### THE VALUE OF COOPERATION

The following is taken from the Buffalo Sanitary Bulletin of March, 1925, and is of interest as an illustration of the value of such reports and the cooperation between State Health Departments:

"The question is often asked 'What is a Carrier?' A communicable disease is due to the entrance into the body of a disease-carrying germ. When such is the case and the person is susceptible to their action, he becomes sick with the particular disease and, after a certain time, evidence of the illness passes away and to all intents and purposes he is well, recovery has occurred.

"There are certain persons, however, who while recovering from evidence of the illness and are apparently well, do not get rid of the germs that caused it, resuming their usual habits of life, scatter them infecting those who may be susceptible. This is a 'carrier'—one who has had a communicable disease, has recovered from the sickness, but has not eliminated the organisms that caused it.

"When these disease-causing germs enter the body they are met by the body's force of resistance, a natural property, more in some than others, but generally in proportion as there is health and vigor. When this resistance is weak, the party is susceptible and falls ill, the severity and duration of the illness depending largely on the amount of resistance and virulence of the germs. With some individuals this force of resistance against germ action is so great that when they invade the body they are at once overcome and do not cause sickness. Such individuals are said to be immune. Some of these immunes receive and harbor germs and scatter them about infecting others. They are also 'carriers,' although they have never had the clinical evidence of the malady.

"Diphtheria and typhoid are notable diseases that determine carriers, and were it not for this factor and especially in the cases of diphtheria, the problem of control would be very much simplified.

"The menace from a carrier is illustrated by a case recently reported to the State Department of Health.

"Four cases of typhoid fever were recently reported from a hotel in the southern part of the state. The District State Health Officer found on investigations that three of the cases had been served by a waitress who had come to the hotel

only a month previous to the onset of these cases. This woman was interviewed just as she was about to take a train for Florida where she had been engaged as a waitress for the winter. She was positive that neither she nor any member of her family had ever had typhoid fever. The Division of Communicable Diseases notified the state health authorities of Florida. Fecal specimens were obtained by them; the second proved to be positive."

As soon as notice was received by our State Board of Health the Bureau of Communicable Disease began its investigation and secured a specimen of stool; a second specimen was necessary to establish the diagnosis. This waitress had come to one of the large winter hotels on the East Coast and but for the notice sent of her arrival it is quite probable that the first intimation of danger would have been an outbreak of typhoid at this hotel.

When found to be a carrier she returned to the North and notification of this fact together with a report of the bacteriological finding was sent to the Health Department of that state.

Another instance of averting a possible typhoid outbreak: During the past winter a letter was received from a neighboring state telling of the departure for a city in the southern part of Florida of a man known to be a typhoid carrier and who had been working on a dairy farm. They felt that it was very probable that he would seek employment on a dairy farm supplying that city.

Immediate notice was sent to the Health Department of that city. The carrier was apprehended and no outbreak occurred. Needless to say that the State Board of Health endeavors to cooperate with other states as well as to report the transfer of a possible source of infection within the state.

#### STATE NEWS ITEMS

*This department is supervised by Dr. Ralph N. Greene, Jacksonville. Members of the State Association are requested to forward to Dr. Greene or the Editor such news items as they may think of interest to the readers of THE JOURNAL.*

Dr. H. Mason Smith, Tampa, Florida, formerly Superintendent Florida State Hospital, and Dr. W. D. Nobles, formerly city health officer at Pensacola, have been appointed to membership on the State Board of Health, according to announcement from the offices of Governor

John Wellburn Martin. Hon. Charles H. Mann has been reappointed and it is understood will continue as president of the board. Doctor Young of Plant City and Doctor Moor of Tallahassee are the retiring members. It is said that Dr. Raymond C. Turck, state health officer, will not accept reappointment.

Dr. Benjamin F. Barnes, Chattahoochee, a capable psychiatrist and ardent radio fan, recently picked up a musical number from Melbourne, Australia. Dr. Barnes has not verified this report and it remains a mystery as to the matter being one of radio reception or picking up a printed copy of some song published in Australia.

Dr. R. R. Killinger, Jacksonville, Florida, surgeon A. C. L. Railroad, was united in the holy bonds of matrimony with Miss Nellie Mae Allen at high noon, June 30th, at the First Baptist Church, Jacksonville. Immediately after the ceremony the happy couple departed for a bridal tour through New England. The bridal couple were photographed by a newspaper photographer, the picture appearing in the morning newspaper on the day following.

Dr. H. Marshall Taylor, Jacksonville, with his entire family, except one son, has sailed for Europe where he will take postgraduate work in Vienna. The Doctor and his family will return in the early part of September.

Mrs. John B. Black, Jacksonville, has recently returned from an extensive European tour.

Mrs. William J. Buck of Jacksonville is spending three months in Europe visiting England, France, Spain and Italy. Dr. Buck is entertaining Drs. Frank Fort and Ferdinand Richards at his attractive home in Riverside, Jacksonville, during Mrs. Buck's absence.

Dr. N. A. Baltzell of Marianna, a member of the State Board of Medical Examiners, is a recent visitor in Jacksonville, he being an ardent Shriner and a merciless witness of the merciless tortures endured by a large class of novitiates at the ceremonial at Pablo Beach on July 2nd. Dr. L. A. Peek was enabled to leave his Ocala comforts long enough to be present also.

Dr. William J. Buck will address the South Georgia Medical Society, Brunswick, Ga., on July 11th. His subject will be "Dose Estimation in X-ray Therapy."

Dr. L. M. Anderson, Lake City, has recently returned from an extensive south Florida visit. He speaks enthusiastically of the splendid work of organized medicine in Tampa, Miami, St.

Petersburg and other cities where he attended medical society meetings.

Dr. John S. McEwan of Orlando, president Florida State Medical Society, was recently in conference with his administrative associates for the purpose of furthering the affairs of the medical society. With his energy and interest applied to the affairs of organized medicine, the society will doubtless have a prosperous year.

Dr. Johnson of New Smyrna was in Jacksonville on professional business July 1st. The doctor is a stable member of the profession and one whose medical ability has won for himself the confidence of a large group of friends and patients.

Dr. Julian Gammon is the proud possessor of a newly born son. It is said the doctor's golf score has materially improved of late.

Dr. M. H. DePass of Gainesville recently returned from spending two weeks at the clinics in New York.

Mrs. J. H. Hodges of Gainesville has been quite ill. It is said that Mrs. Hodges is now convalescent.

Dr. Ralph J. Greene of Perry, Florida, has recently returned from a visit to Johns Hopkins Hospital. This particular hospital is located in Baltimore, Maryland, some ten blocks from the B. & O. depot.

Organized medicine saves the world.

If the farmers would organize as do the plumbers, railroad firemen and plasterers, dragging down twenty dollars a day for eight hours' work, in seventeen short months half of this great nation would be "hungry."

Doctors don't organize to help themselves.

They are a bunch of jealous temperamentals.

Their organization benefits humanity at large

and is different from any other organization of men in the world.

*Food for thoughtful consideration.*

Dr. John S. McEwan is spending three months in Europe. During the month of August he will be in Edinburgh taking a course in operative surgery under Dr. McTosh.

The Florida State Board of Health is holding a clinic for the study of "Creeping Eruption" at the executive offices in Jacksonville from July 10th to July 20th. The clinic is in charge of Dr. J. Lee Kirby-Smith, who has done much research work in this particular malady. Associated with him in the study are Dr. W. E. Dove, entomologist, and Dr. G. F. White, insect pathologist, both of the U. S. Bureau of Entomology. This group of workers during the past year recovered and identified a microscopic Nematode parasite (*Agamonematodum Migrans*) as being the cause of "Creeping Eruption." During the clinic being held this month, they will carry out a number of experimental measures in determining the most efficient and painless method of treatment.

At the last meeting of the American Medical Association, Dr. Kirby-Smith presented a resume of his investigations of "Creeping Eruption" to the Section on Dermatology.

Dr. and Mrs. Ralph D. Murphy of St. Petersburg have sailed for Europe, contemplating an extended tour. Dr. Murphy will spend much of his time in Vienna doing special work in Otolaryngology.

Two hundred and fifty-two applicants were examined for license to practice medicine in Florida at the meeting of the Board of Examiners held at Tampa, June 15th and 16th. Many physicians of international reputation were listed among those applying for license.

## ABSTRACT DEPARTMENT

### SURGERY

A Technique for Simultaneous Implantation of the Right and Left Ureters Into the Pelvic Colon Which Does Not Obstruct the Ureters or Disturb Kidney Function. Robert C. Coffey. Northwest Medicine, May, 1925.

This paper presents the technique of an operation designed to dispose of both ureters in cases of complete resection of the bladder, supplying therefore a last link in the fundamental procedure of disposing of malignant disease of this organ, namely, complete removal.

Following up a principle in applied physics which he demonstrated in 1910 concerning the implantation of a duct of an organ into a hollow viscus of greater pressure, which principle requires that the duct of the first organ shall be collapsible and shall run for some distance under the collapsible mucous membrane of the organ into which it is to be implanted, Coffey has designed an operation by which he overcomes the blocking of the implanted ureters of the site of



the implantation. He places small rubber tubes up into the ureters extending above the point of implantation, anchors them at the ends of the ureters and pulls them out of the rectum by attaching their ends to a rectal tube exposed through the implantation openings in the recto-sigmoid. The rubber tubes maintain the patency of the ureters until the edema has subsided and then come away, leaving the patent ureters discharging the urine into the intestine.

Coffey reports one clinical case in which the new operation was done. The tube was used to implant the ureters separately, at different operations, on a cancer of the bladder, and each continued to drain urine from the tube without interruption, the patient recovering from both operations without the Sligh test disturbance. He feels that the operation removes the last bar to successful implantation of the ureters in that it preserves the patency of the ureters and therefore the integrity of the kidneys during the first week after the operation, the period of danger from blocking of the implanted ducts from edema at the site of the implantation. J. K. S.

An Oblique Transrectus Incision for Gall-bladder Operations. A. O. Wilensky. *Medical Journal and Record*. March, 1925. Volume CXXI.

Dr. Wilensky's incision begins about one inch below the tip of the ensiform process, extends obliquely downward and outward to the outer border of the rectus to the right and is carried through all of the superficial structures and the anterior sheath of the rectus muscle. The fibers of the rectus are bluntly separated near the center of the muscle, and any fibrous intersections of the muscle are dissected free. The fibers of the muscle are retracted and the posterior sheath and peritoneum are divided in the same plane as the superficial structures.

This incision gives an excellent exposure of the gall-bladder, can be enlarged by a vertical incision, and is easily closed. The advantages and disadvantages of the following incisions are carefully discussed:

1. A tranverse incision combined with a vertical incision (Perthes, Czerny, Koenig-Kehr);
2. The tranverse incision (Duncan, Morrison, Sprengle);
3. A vertical incision combined with an oblique incision (Mayo-Robson);
4. An oblique incision made directly through the abdominal wall (Curoisier, Kocher, Kohrte), and he also calls attention to the following points which makes his incision superior to the others:

1. The possibility of enlarging the incision;
2. The ease of execution;
3. The visibility of the intra-abdominal organs, and the ease of intra-abdominal manipulation;
4. The possibilities of drainage;
5. The likelihood of subsequent hernia.

G. H. E.

Intussusception: A Series of Twenty Consecutive Cases. G. M. Gray. *Lancet*. February, 1925. Vol. CCVII.

In Gray's series of intussusception of children all but three were under one year of age and all but three were or had been breast-fed and were apparently strong and healthy babies. Two had a previous history of stomach disturbances. He also calls attention to the fact that a mobile caecum is apparently an important factor in the development of the condition. As in his series 1900 there was a distinct mobility of the caecum and ascending colon.

The symptoms were pain, vomiting, blood in the stool, and presence of abdominal tumor. Pain was always present and also a tumor mass which varied in size and position. The vomiting varied greatly, in several cases being practically absent. The passing of blood was present in nineteen cases, but in all but two was a late symptom.

The treatment is immediate operation, entrance being through a right paramedian incision. If possible he uses only nitrous oxide, rarely ether, and he delivers the tumor to reduce it. In his series there was only 10 per cent mortality. This low per cent being due to the early recognition and operation in practically all the cases.

G. H. E.

## MEDICINE

Anatomic Findings in Essential Hypertension. *Arch. Int. Med.* 5:650, May 15, 1925. Arthur M. Fishburg.

The author believes the consideration of essential hypertension as a distinct nosologic entity is justified from both a clinical and anatomic viewpoint. Of eighty-two cases coming to necropsy of chronic hypertension, seventy-two, or 88%, were of the essential type. All of the 72 cases showed well-marked arteriolar changes. The characteristic changes occurring in the kidney are hyaline changes and the hyperplasia of the internal elastic membrane. The arterioles of the kidneys were involved more frequently and intensively than in any other portion of the body. The splenic arterioles were involved in two-thirds of the cases, the pancreas in about one-half, the hepatic in less than one-third and the cerebral in one-fifth. Involvement of the splanchnic vessels was not found with any degree of

constancy. Arteriosclerosis is invariably associated with hypertension. Senile arteriosclerosis has little relation to hypertension. The arteriosclerosis of hypertension is a pathological exaggeration of normal changes due to increased strain. The kidney changes are believed to be secondary to the hypertension. The large majority of cases suffering from essential hypertension do not develop any marked renal insufficiency. The lesions in the kidneys are focal and not diffuse.

E. W. B.

**Nephrosis: A Clinical and Pathologic Study.** Joseph Kaufman, M.D., and Edward Mason, M.D., *Arch. Int. Med.* 5:561, May 15, 1925.

The principal characteristics of nephrosis are extensive edema, low blood pressure, abundance of albumin in the urine of high specific gravity, numerous casts with the absence of blood, a degenerative process in the epithelial cells, globulin in the urine, inability to excrete salt, normal blood urea and creatinin, the absence of eye changes and a slowly progressing anemia.

Three cases are reported. Number 1 represents uncomplicated nephrosis from beginning to end. Number 2 represents a mixed type, showing some fibrous tissue proliferation. Number 3 showed a small white kidney and marked arteriosclerotic changes in the blood vessels. All showed degenerative changes in the tubular epithelium.

Pure forms of nephrosis are uncommon. Combined forms, showing productive or exudative changes are more common. Such forms usually show an elevated blood pressure, eye changes and urea retention.

The authors believe nephrosis is an early manifestation of a general systemic, cellular, degenerative process of unknown origin. The edema has practically no relation to the kidneys but depends on an altered state of capillary permeability. A low basal metabolism is reported which is attributed to altered cellular activity. True nephrosis shows a tendency to progress to a secondary contracted type as a result of a process of organization.

E. W. B.

### OBSTETRICS

"Modified Rectal Analgesia in Obstetrics," J. T. Gawathmey, *American Journal Obstetrics and Gynecology*, Volume IX, No. 3, March, 1925.

The author summarizes his method of synergistic anesthesia in childbirth and gives revised technique and additional statistics to those in previous articles. He gives the toxicity of ether

and magnesium sulphate, and states that they act synergistically in producing anesthesia without causing any increase in toxicity. In obstetrical analgesia magnesium sulphate is used not as an anesthetic, but as an analgesic and a potentiating agent for the ether. The toxicity of magnesium sulphate as used here need not be considered. As the average anesthetic dose of ether in oil is five ounces and the average for analgesia two and one-half ounces, the patient is never so relaxed that an expert anesthetist is needed.

Quinine is safe in all stages of labor and is just as important as the ether and the magnesium sulphate. Without it, uterine inertia, delayed labor and increase in incidence of forceps results.

The technique is as follows: When cervix is two to three fingers dilated, and pains four to five minutes apart, lasting thirty to forty seconds, give an intramuscular injection of morphine gr. 1/6 in 2 cc. of a 50 per cent magnesium sulphate solution with 2½ per cent novocaine. Follow in twenty to thirty minutes with the following formula given as retention enema:

Quinine hydrobromide . . . . .	Grains	20
Alcohol . . . . .	Drams	3
Ether . . . . .	Ounces	2½
Olive oil q. s. ad. . . . .	Ounces	4

If necessary, repeat hypodermics of magnesium sulphate without morphine.

Cæsarean section or forceps cases do not contraindicate it. Over 90% of patients are relieved of pain. Over 1000 cases have been treated in New York Lying-In Hospital and they reach the conclusion that:

1. Method is safe.
2. Pain is relieved in some measure in over 90 per cent of all cases.
3. Labor is not delayed.
4. Baby is usually born crying.
5. Delivery with forceps is decreased.
6. The postpartum contraction of uterus is good.

Final result depends largely upon experience with this method and the judgment of the obstetrician.

S. R. N.

### OTOLARYNGOLOGY

Bell's Palsy, Four Cases of Infectious Origin, Virginius Dabney, M.D. F.A.C.S., Washington, D. C., Professor of Otolaryngology, George Washington University.

Definitely differentiating the clinical entity of the classical Bell's Palsy from seventh nerve paralysis by pressure of growths, parotitis, encephalitis, mastoiditis, syphilis, etc., Dabney says

"it is my firm conviction that every case of Bell's paralysis will be found to be of toxic origin, if care is exercised in the search for such a cause," and reviewing, offers opinions of Charcot and Neumann against the time-honored theory of "cold and exposure" as true etiology. Explaining in detail the three anatomical segments of the seventh nerve with their individual branches, as follows: (1) Those given off within the fallopian canal; (2) those extracranial and given off before the terminal division; (3) the temperofacial and cervicofacial divisions. This threefold division is not merely an anatomic nicety, but will explain why some cases of Bell's paralysis show ear symptoms like tinnitus and slight deafness, indicating involvement of the chorda tympani and stapedius, while others are complicated by perversion of taste and impaired motility of the tongue, showing implication of the chorda tympani and glossopharyngeal. Again, there may be nothing but uncomplicated facial paralysis, where the inflammation attacks the nerve after its exit from the stylomastoid foramen.

Supporting the toxic idea the anatomy of the nerve would conform, as blood carried infection could be selective in its attack affecting the nerve at any point and especially in the narrow canal would it be manifest owing to pressure from effusion in the nerve sheath with locking at the stylo-mastoid foramen which is smaller on the right side, especially in women, and it is record that Bell's Palsy does occur more in women and more on the right side.

Herpes is noted as an analogous condition formerly believed to be due to cold but at present known as infective ganglionitis. Dabney accepts cold as contributing, saying it exacerbates the chronic focal condition, as latent dental abscesses, tonsillar and sinus infections, these becoming active following exposure, etc., and in four cases demonstrates the relationship between the exposure and the focus and paralysis, with cure only after removal of the focus.

J. L. B.

## PEDIATRICS

The Use of Triple Distilled Water in the Treatment of Children, Theodore Le Boutillier. *Archives Pediatrics*, Volume 42, May, 1925.

Reference is made to the intravenous or intramuscular injection of small quantities, 1 to 2 cc. of triple distilled water in 250 cases treated by the author. His conclusions are that it affords wonderful relief in cases of vomiting of the cyclic type and cases accompanying acidosis. Remarkable results were secured in cases of pertussis, bronchial asthma, various forms of neuritis, urticaria, angioneurotic edema and eczema. The action is through homolysis, breaking down of a certain number of red blood cells and liberating their contents into the blood stream. These products are absorbed into the tissues and start an acquired immunity with subsequent improvement which is frequently startling. The distilled water should be used within four days of its preparation.

J. D. L.

---

A Study of Thymus Glands, Guy L. Bliss. *Archives Pediatrics*, Volume 42, April, 1925.

The author reviews some of the supposed functions of the thymus gland and furnishes a list of symptoms that may accompany an enlarged or persistent thymus. He admits the difficulty that attends a diagnosis of enlarged thymus since the norm for the gland in a baby of given size, age and weight has not been established and prefers the term "symptom producing thymus" to "enlarged thymus." All apparently enlarged thymus glands do not produce symptoms and may not be dangerous, though in most cases a dangerously enlarged gland presents a definite symptomatology.

Diagnosis of symptom producing thymus must be made from symptoms exhibited in connection with X-ray findings. The cause of thymic death has not been proven.

X-ray treatment carefully applied so as not to injure contiguous structures is the preferable means of treatment.

J. D. L.



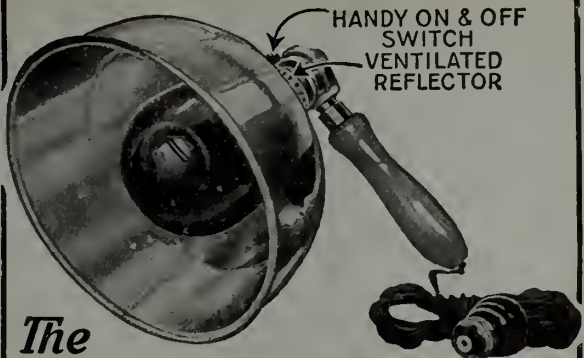
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2. If the dog dies or is killed or disappears in less than ten days after biting the patient.
3. If the dog is unknown.
4. If the dog is living and after observation for ten days develops rabies, dies under suspicious circumstances, or is sick.

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# THE JOURNAL

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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Number 2

## CANCER OF LIP, RESULTING DEFORMITY, PLASTIC REPAIR\*

JOHN E. BOYD, M.D., F.A.C.S.,  
Jacksonville, Fla.

The presence of a sore in any of the orifices is a source of danger. Carcinoma is now conceded to be the sequence of repeated mild irritation. This etiology differs materially from that of sarcoma. Sarcoma is the sequence of a moderately severe trauma; never of a severe trauma. More plainly stated, you never get a sarcoma at the site of a fracture. You may have a sarcoma and subsequently a fracture, but you never get a sarcoma where the bone is broken. Where you hit the bone with a baseball; with a bat or strike it against the edge of a chair, stopping short of fracture; that is the type of trauma that produces sarcoma.

In the study of sores on a lip it becomes necessary to eliminate tuberculosis or other infection. Consider tuberculosis and analyze the difference in the clinical course. Tuberculosis is at first a local manifestation, as in carcinoma; it destroys by the multiplication of cells, as in carcinoma; there is a local center of necrosis, just as in carcinoma. Second, it is transmitted to the neighboring lymphatics. Third, it may be transmitted to the blood stream and to other positions in the body. Fourth, it destroys life.

These similarities, however, between malignant disease and infections are *not* continued in the pattern of the cellular metastasis. In malignant disease metastasized cells *always* reproduce the pattern of those present at the primary focus. For example, if you have a squamous cell epithelioma of the lip and a metastatic cancer appears in the femur, it would be a squamous cell epithelial cancer. In infection, on the other hand, it is the cells of the tissue in which the infection lodges that become active. If you have a tuberculosis of the lip and get a metastatic tuberculosis of the femur, there would not be epithelial cells, but osseous cells, at the point of infection. The cell itself is the destructive element in both sarcoma and carcinoma; the micro-

organisms are the destroyers in all other varieties of infection. The biotic and toxic effects of the microorganisms cause the changes that occur with infection. The multiplication of the cells produces the changes that occur with malignant disease.

In cancer, the question that first arises is, how soon after the first erratic epithelial cell penetrates its basement membrane, which is the one condition that makes it a cancer—how soon after that do these cells pass into the neighboring lymph spaces, and how soon are they passed on into the first lymph filter, the first lymph node? This question has never been answered. It is for the above reason that we are not justified in saying that if we could have the cases earlier we could get results.

In the report of St. Bartholomew's Hospital in London, which contains an analysis of the cases for twenty-five years, it is noted that the cases operated upon before demonstrable enlargement of the superficial lymph nodes, showed a *final* cancer mortality of 52 per cent. Of the cases operated upon in which the nodes were palpable, and in which the nodes had been removed, 75 per cent died a cancer death.

A carcinoma is or is not dangerous, from a metastatic standpoint, in proportion to the lymph supply of the zone primarily involved. Carcinoma occurs more frequently in a rich lymph supply zone than in a lesser lymph supply zone. The lip, as we know, is one of the richly supplied lymph zones. Metastasis should, and does, take place earlier here than it does in any other portion of the body.

In analyzing carcinoma of the lip we find that there are distinct types of recurrence: One occurs in the lip itself, in the lymphatics, far from the point of primary invasion. Another occurs, first, in the lymphatics of the upper triangle of the neck; second, in the deeper structures of the neck, and third, one commonly overlooked, in the small lymphatics situated just below the foramen mentum.

Dr. John B. Murphy, in his valuable "Clinics," reports the case of a man operated at Mercy Hospital for epithelioma of the lip. This man returned nine years afterwards with an enlarged

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg, May 19-20, 1925.



lymph node situated under the anterior portion of the submaxillary salivary gland. The question arose—how long had that infection been present in that gland? It had not returned “in loco”; but nine years after the original operation he removed a squamous cell epithelial growth from this lymph node, which, as Doctor Murphy says, means what? It means that it had been there nine years, because there is no such thing as a *primary* squamous cell carcinoma occurring in a *gland*. This leads us again to the problem. How early does transmission take place? An answer to this question would give us a more rational or definite basis on which to render an opinion as to when we remove cancers, early or late.

A. C. Broders, M.D., of the Mayo Clinic, in a review of 537 cases says it is an error to classify cancer of the lip as cancer without any distinction as to the degree of malignancy.

It is a well established fact that some cancers of the lip are fatal to patients and others are not. Different theories have been advanced in explanation of this. It is claimed that some persons are resistant to cancer. Again, there is no doubt that a large proportion of cancer cells are destroyed by the defense cells of the body. Of these the fibrous connective tissue cell is the most important since it cuts off nourishment from the cancer cells.

The endothelial leukocyte and lymphocyte evidently also play an important role in the destruction of cancer cells, for practically always they may be seen in the neighborhood of a cancerous growth. Foreign body giant cells that are most probably formed from the endothelial leukocytes are not infrequently found lying adjacent to cancer cells.

Doctor Broders is of the opinion that the most important factor in squamous cell epithelioma of the lip seems to be the degree of its cellular activity.

His explanation is as follows:

“The cells of some epitheliomas of the lip show a marked tendency to differentiate; that is, to produce a growth similar to the normal; the pearly body is an example. The pearly body corresponds to the horny layer of the epidermis. In other squamous cell epitheliomas there is no differentiation at all. In the large majority of these growths whose cells do not show a tendency to differentiate, or at least very little, there are many mitotic figures. Upon the above theory he

graded these lip epitheliomas according to differentiation and mitosis, laying special stress on the former. Some epitheliomas of the lip are very active and from the start show little or no tendency to differentiate.

“With that as a basis four groups were graded. In a tumor of Grade 1 malignancy, about three-fourths of its structure contains differentiated cells, and one-fourth undifferentiated cells. In a tumor of Grade 4 malignancy, all the cells are undifferentiated. Between these two extremes are tumors of Grade 2 and Grade 3 malignancy.

“From a review of the known cases of death from epithelioma of the lip, it was found that the mortality from this cause was 100 per cent in cases in which malignancy was graded 4; 84 per cent in cases graded 3; 55 per cent in cases graded 2, while there were no deaths in the group graded 1. Some epitheliomas grow more malignant with time; others increase in malignancy and then retrogress. Unquestionably an epithelioma of a low grade is made more malignant by irritating with chemicals such as hydrochloric acid, nitric acid, silver nitrate or arsenic paste.”

This classification of Doctor Broders has been emphasized by Percival Cole of England. Again Meleney in Pekin, Aurelieno Urrutia in Mexico, Brewer of New York and Martzloff of John Hopkins have independently proven the correctness of Broders' classification and have all agreed to its great value in prognosis, as well as its aid to the decision of the surgeon regarding the value of surgery in a particular case.

MacCarty has demonstrated early cancer in the pithelium at or near the edge of gastric ulcers; practically the same process is found in early cancer on ulcer of the lip. In the lip the cancer starts in the stratum germinativum of the epidermis at our near the border of the ulcer. Not all cancers of the lip are preceded by ulcer but the majority are.

After reviewing the 537 cases from various standpoints, Doctor Broders deduced thirty-seven different conclusions. All of these deductions are interesting but too voluminous to quote in this paper. I will, however, mention a few of the more interesting:

(1) It occurs more often in males, the proportion being 69 to 1.

(2) The greatest incidence of the disease is at the average age of 57.3.

(3) It occurs more often in farmers, 56.7 of his series.

(4) A family history of cancer plays a negligible part.

(5) The site of cancer was preceded by a sore or ulcer in 63.3 per cent of the cases.

(6) One-fifth of the cases did not use tobacco.

(7) Of the tobacco users 93.3 per cent smoked and 18.4 per cent of these used a pipe.

(8) Trauma plays a negligible part.

(9) The duration of the lesion shows a marked variation, from 0.08 years to 28 years, with an average of 2.58 years.

(10) The lesion originated on the lower lip in 95.6 per cent of the cases, on the upper in 3.5 per cent.

(11) Of the patients operated on and traced 40.5 per cent are dead.

(12) Of the living 92.8 per cent report a good result.

(13) Of those that died 63.6 per cent died from epithelioma.

(14) Those previously treated with pastes, radium, etc., did not obtain such good total results as those not so treated.

There is a type of case that, at the time it falls into your hands, has had numerous treatments, which afford temporary check of the progress of the disease, but finally results in much loss of tissue and consequent deformity. It is to this particular type I invite your attention. I also desire to call your attention to a special plastic operation designed for relief of this deformity.

The operation referred to was obtained from an article in *Surgery, Gynecology and Obstetrics*, Vol. XXXVI, No. 1, January, 1923, written by Clarence A. McWilliams and Henry S. Cumming of New York City. The flap obtained for the plastic repair of severe deformities of the face, including those of the nose, cheeks, chin and lips, is not original with these men. Dufourmental in 1918 and Sebileau in 1920, have taken hairy, temporal forehead flaps to make up losses on the face. By taking the temporal frontal flap from each side, the two halves being left attached to each other in the median line, the whole upper or the whole lower lip can be reconstructed. In each pedicle should be incorporated the superficial temporal artery, thus affording a very rich blood supply. By Thiersch grafting the undersurface of the portion of the flap, that is, to cover in the defect and be toward the mouth, its surface becomes covered with epidermis, which,

being continually bathed with saliva, rapidly takes on the character of mucous membrane and does not contract. To prevent subsequent contraction of the transplanted flap, two procedures are needed: first, the pericranium should be left attached to the intended actual transplant, and, secondly, the undersurface of the pericranium should be Thiersch grafted before it is transplanted. Having formed your flap, skin-grafted the part including pericranium, pedicled the temporal portion, it is placed in position with perforated silk suture. It is not ready for transplanting for at least two weeks.

The dividing of the pedicle can be done in another two weeks. If it is a double-pedicled flap you divide one pedicle at a time with at least ten days between.

After dividing the pedicle or pedicles you then begin the minor operations looking towards the fashioning of a natural lip.

My limited experience with this flap leads me to feel that it has many advantages over a neck or chest flap, especially for the use referred to in this paper.

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#### CASE REPORTS OF PLASTIC REPAIR OF MUTILATING OPERATIONS OF LIP AND CHEEK FOLLOWING RADICAL REMOVAL OF CARCINOMA

F. A. COPP, B.A., M.D.,

Jacksonville, Fla.

The first patient I wish to present is Mr. J. C. Coleman who was admitted to the Duval County Hospital March 19, 1924, and assigned to my service, that of plastic surgery.

In this presentation the only important points of his history are as follows: Age, 76. No family history of malignancy. Carcinoma developed on the upper lip near the left angle of the mouth four years ago. Was treated with cancer pastes by a so-called specialist in New York with disappearance of the lesion for six months when it returned at the original location. Came to Florida and was treated with radium by a physician of Jacksonville with healing for another six months. On reappearance the same physician



Case 1. J. C. Fig. I.  
Lesion healed after cautery  
removal.



Case 1. J. C. Fig. II.  
Flap prepared.



Case 1. J. C. Fig. III.  
Flap sutured into defect.



Case 1. J. C. Fig. IV.  
Pedicle severed and returned  
to original site.

applied radium both outside and inside the mouth. Four months later the lesion was again active when radium needles were used in the tumor and X-ray treatment given. A few months later it was again necessary to use the same type of treatment. Three weeks later the face was considerably swollen and the lesion was necrotic. The cheek near the left angle of the mouth was perforated and the opening would admit the tip of the little finger. The patient then applied at the county hospital for treatment.

March 22, 1924, under ether anesthesia, the left half of the upper lip, a portion of the cheek, and the left third of the lower lip were removed with the electric cautery. The roughly circular portion of tissue excised was two inches in diameter.

Six months later healing was complete and the patient appeared as in Fig. 1, hideously deformed, unable to hold the saliva in the mouth, able to eat with difficulty, and unable to smoke.

September 19, 1924, again under ether anesthesia, two parallel incisions one and one-half inches apart were made from the left zygomatic arch vertically to the top of the head where they were separated to surround a portion of the scalp slightly larger than the defect as at first produced. The enlarged end of the flap included the pericranium. The pedicle consisting of skin only was tubularized with several sutures. Two large Thiersch grafts from the thigh served to cover the raw surface of the enlarged end of the flap. Celluloid tissue was placed between the flap and the head to prevent reunion of the raw surfaces. This operation is demonstrated in Fig. 2.

Thirteen days later, again under ether anesthesia, the flap was turned down and sutured into the defect after thorough removal of the scar tissue, as seen in Fig. 3. The Thiersch grafts had taken and the buccal surface of the flap was completely epithelialized. No dressing was applied.

October 17, 1924, as demonstrated in Fig. 4, the pedicle of the flap was severed, incised along the line of union, unrolled and returned to its original site, the remaining raw edge of the transplant sutured in place, and the ray area on top of the head covered with Thiersch grafts. No dressing was used except for the latter.

November 6, 1924, after careful measurement the mouth was formed and false mucous membrane sutured to the skin edge. No dressing was used. Fig. 5 shows the result two weeks after the final operation. The edema present in the transplant will disappear in time. The patient can now eat, drink and smoke comfortably. During the course of the several operations it was necessary to call Dr. Shaler Richardson into consultation to treat an ectropion of the left lower eyelid caused by the contraction of the tissues on that side of the face. The ectropion subsided following Ziegler cautery puncture.

The next patient I am showing through the courtesy of my friend, Dr. John E. Boyd, who gave me valuable advice and assistance in the operations on the patient just shown. The case demonstrates the same type of operation except that a double pedicle flap was used.

The patient, R. L. Talley, was operated upon by Dr. Boyd at St. Vincent's Hospital. He is 64 years old and his history is unimportant except as it relates to the disease for which he was





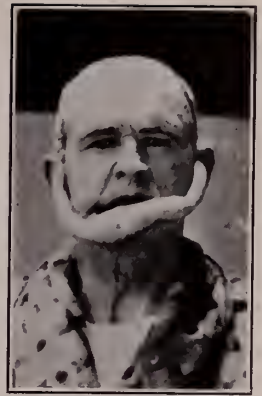
Case 1. J. C. Fig. V.  
Result two weeks after final  
operation.



Case 2. R. T. Fig. VI.  
Before cautery removal.



Case 2. R. T. Fig. VII.  
Double flap prepared.



Case 2. R. T. Fig. VIII.  
Flap transplanted.

operated upon. In 1908 a small scaly sore appeared on the lower lip near the right angle of the mouth. For twelve years there was no treatment and no change in the lesion. In 1919 a definite ulcer formed and began to enlarge. Another so-called cancer specialist applied a paste. The lesion healed for eight months, when it reappeared at the original site. The "specialist" then sent a paste which the patient applied. Healing did not take place this time. He was treated with radium in 1921, and the lesion healed for a few weeks and recurred. The same treatment was used several times with the same results. In May, 1922, a neck pedicle-flap was formed to repair the defect then present, but before it could be transplanted the lesion was again active. The following month another cancer plaster was applied without benefit.

A physician in Jacksonville was then consulted who treated the diseased area with radium on two occasions. The patient was then referred to Dr. Boyd for repair of the large defect present. Fig. 6 illustrates the condition. A small ulcer was still present.

In December, 1922, a wide cautery excision was done. Two months later it was again necessary to use the cautery to remove a portion of the cheek where recurrence had taken place.

When healing had finally resulted a double pedicle-flap was prepared as shown in Fig. 7, on May 1, 1923.

Ten days later the stirrup flap was turned down and sutured into the defect as demonstrated in Fig. 8.

On the 29th of the same month one pedicle was severed and returned to its bed, and on the 12th of June the other pedicle was similarly

treated. These steps can be seen in Figs. 9 and 10. Subsequent to this there were several minor cosmetic operations, and the condition of the patient was as shown in Fig. 11.

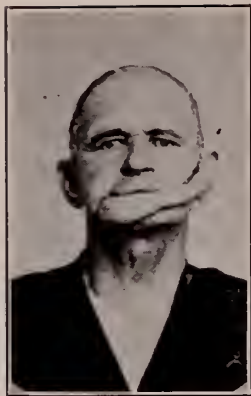
The pathological report on both of these cases was basal cell carcinoma.

The advantages of this type of operation are: (1) Thickness of scalp tissue. (2) Assured blood supply (the superficial temporal vessels). (3) Comfort of the patient. (4) Additional deformity on top of the head where it is less noticeable than on the face or neck. The defect of this method of repair is that of all plastic operations, viz, immobile tissue replacing mobile structures. In replacing one lip the normally mobile one can effect a perfect closure of the mouth. With repair of both lips this is, of course, impossible.

#### Discussion of the Papers of Drs. Boyd and Copp.

*Dr. Gerry R. Holden, Jacksonville:*

In discussing this paper, I wish to first consider the treatment of choice in superficial cancer. I think we may lay down as an axiom that the best treatment of any superficial cancer is surgical excision, provided that our incision can go beyond all the tissue that is infected with cancer and provided that the resultant deformity is not unduly great. In cancers of the face, however, it is seldom that we can satisfy these conditions. In such face operations it is difficult to get around all of the cancer, and it is almost impossible to make your incision so that you will not have great resulting deformity. Therefore, cancers of the face are the favorite field for radiotherapeutic treatment as well as treatment by cauterization, paste and other means.



Case 2. R. T. Fig IX.  
One pedicle severed and  
returned.



Case 2. R. T. Fig. X.  
Second pedicle returned to  
original site.



Case 2. R. T. Fig. XI.  
Final result.

When should we use radiotherapeutic treatment in facial cancers, and when should we resort to the more drastic measures as outlined in these two papers of Drs. Boyd and Copp? Those of us who are using radiotherapy know that there are certain types of these cancers which can be treated by radiotherapeutic measures as well as by operative measures. These cases are as follows: In basal-celled epitheliomas and possibly squamous-celled epitheliomas of low grade, providing that the lesion is no larger than a quarter in diameter, and providing that it has had no previous treatment, we are justified in using radiotherapeutic measures, either X-ray or radium. However, we have a very great many cases in which these conditions are not satisfied, and these two cases reported by Dr. Copp fall in that class. They were both men who had had previous treatment of various sorts, caustic, electrical, and radiation, both X-ray and radium, and we had the tissues of these men in a condition in which they resisted any further radiation.

I was associated with Dr. Boyd in the treatment of the second case, and I learned a great deal by it. I radiated him first with radium needles as preparatory for Dr. Boyd's operation, and the reaction of that skin was absolutely different from that of a man who has had no previous radiation. Instead of a normal reaction, we got a melting away or disintegration of the tissues, leaving a poor surgical field for later surgical work.

I think that the proper treatment of the cases such as Drs. Boyd and Copp have described, is as follows: When these cases come to you after a long series of previous treatment, whether it be caustic cautery or radium, I believe that the only way to handle them is the wide type of sur-

gical operation with disregard of facial deformity, endeavoring to get as far outside of the lesion as you can, and then repair your resulting defect with the measures which have been laid down in these two papers.

In conclusion I want to congratulate both Dr. Boyd and Dr. Copp on these cases, not only on the manual dexterity employed, but on the infinite patience which is required to handle them. Having them around in the hospital for month after month, and still being able to smile pleasantly and treat them patiently until the end of the necessary time requires an amount of patience that the majority of us do not possess.

*Dr. John S. Helms, Tampa:*

I have no grounds on which I could very well differ from Dr. Boyd. I certainly think he has presented a most important subject in a very scientific and practical way, and I enjoyed hearing it.

Of course, in dealing with these lesions the first thing that we must know or must do is to make the proper diagnosis. The things that malignancies of the lips must be differentiated from were mentioned pretty completely by Dr. Boyd. There is one class of cases, however, that I think he failed to mention, and this did not occur to me until the last year. The experience of two cases, however, led me to believe that one should be careful in differentiating malignancy of the lip from fusiform bacillus infections or Vincent's angina. I ran across a case which was diagnosed as malignancy of the lip without however having any study of the tissue. He was treated with radium and by other methods, and finally the diagnosis was determined to be fusiform bacillus infection. This case presented a

most dreadful spectacle in its last aspect. The entire lower lip and jaw bone had disappeared except a very thin layer of the jaw with a part of the tongue and it was definitely diagnosed as fusiform bacillus infection and was not a malignancy. It resisted every form of treatment.

I had another case which showed a complete erosion of the nasopharynx and might have been taken for malignancy. There were no lesions, however, on the lip, and that case does not directly relate to the subject, but I mention it for the reason that it might be taken for malignancy. This case presented a most awful spectacle, and finally died in spite of all treatment given.

The work of Broders in determining the degree of malignancy in these cases, in my judgment, marks an epoch in the study of malignancy of the lip. The relative merits of the different forms of treatment of cancer of the lip finally rest on the degree of malignancy rather than the effectiveness of the individual treatment. So the determining of the degree of malignancy is a very important factor in these cases, for it determines not only the plan of treatment as a rule, but it also determines the final results with the prognosis in the case.

I desire to congratulate Dr. Copp upon his splendid presentation of constructive plastic repair of the defect resulting from the treatment of these cases. Plastic constructive surgery is a special field itself. It requires special training and it requires ingenuity, and as Dr. Holden suggests, it requires a lot of patience. I am glad to know that Dr. Copp has developed this branch of surgery so highly.

*Dr. J. S. McEwan, Orlando:*

I could not let this opportunity pass without congratulating these two men on their work. I think, as Dr. Helms has said, one of the most difficult branches of surgery is plastic work. It takes a genius to do it, a mechanical genius, and he must have, as Dr. Holden has said, a lot of patience.

I would like to ask these men if they have had a recurrence of either one of these cases as yet?

Now, I should like to add one thing to the treatment of these superficial epitheliomas. I think one of the greatest aids today, together with radium and X-ray, is what Dr. Ward, of Baltimore, has described lately in various journals and that is electrothermy. Since seeing this method used in Baltimore last fall, I adopted it, and have been using it for the past six months.

I think today that in treatment of superficial cancers, epitheliomas, and all cancers that we can get access to, this method of removing them is ideal. With this electrothermy knife or needle you can get under, take out the specimen, and get primary union without scar, loss of tissue, or burning as with the ordinary cautery. Just last month I was told of a case where the entire process was removed with this electric needle and there was no hemorrhage. If you use it with the proper strength you can close it up and get primary union.

The technique to prevent the spread of this infection is by introducing a ray of heat around the epithelioma or cancer and then cutting it out by applying the electric knife to the base. You then get a clean wound and you get no sloughing and no hemorrhage. I believe this is going to be a great aid in the treatment of superficial cancer.

*Dr. Kirby-Smith, Jacksonville:*

I have not much to say on the subject of surgery or surgical repair, after extensive cancer, but I would like to have a few words to call your attention to a simple and important measure which I consider valuable to medical men in bringing about the prevention or the cure of cancer of the lip without the patient going years with extensive ulcerations, viz: education of the public to seek medical relief early for any abnormality of the skin of the lip. Fifteen or twenty years ago it was the commonest affair in the practice of medical men to see patients coming in with extensive ulceration of the lip from long standing cancer of the lip. I think now that it is a rarity that you see cases of the type Drs. Boyd and Copp have shown us. Remember that cancers, either of the basal celled or the squamous celled type of epithelioma of the lip, begins as a rule in the horny layer with a small ulcerated patch of hyperkeratosis. Some of these are irritated by a pipe or some instrument in one's occupation. These are the conditions that can be cured.

The surgeon, if allowed, would give us the prettiest and cleanest results with less scar tissues and the early relief of the patient. But unfortunately general surgery in the past has instilled in the minds of the patients the fear and dread of the mutilation by surgical treatment as well as by the process of the disease, until it was almost impossible for the surgeon to see these cancers in their early stages. Some patients in



the past have survived from one month to one year, but were never cured.

Education of the public about the cancer situation is being emphasized by the American Society for the Control of Cancer, and especially by Dr. Bloodgood, of Baltimore, who has spent a great amount of time in going around the country preaching this doctrine for the benefit of humanity, explaining to the people that if they expect a cure they must report to the physician in time. A simple growth of the lip, basal-cell type in its beginning, extends laterally. If it is of the prickle-cell type it will extend down to the glandular processes and very rapidly undergo malignancy. The types we see here today, basal-cell, may go on for sometimes years and years. I think these in the worst stage if properly treated with combined surgery and with the use of radium and X-ray all evidence of cancer can be destroyed, but is the cancer itself permanently cured? As Dr. Boyd mentioned, there are patients, occasionally, who seem to have a predisposition for malignant forms of cancer, and these in the end succumb to the disease in spite of everything we can do. These cases are hopeless. What can we do to permanently cure a patient with epithelioma of the lip with the glands involved? Very little, I think. I don't care what the treatment is, after the affection becomes glandular it is hopeless. In speaking of that, before I close my remarks, I want to mention a case I saw last fall. A woman consulted me at this time with a small superficial ulcerative epithelioma of the nose, and with the lymphatics apparently uninvolved. I used the usual curettement followed by X-ray treatment with apparent good result. I saw this individual four months later and she was in perfect shape. Two months after that I saw this lady again and this time she had a large involvement of the sublingual glands. Who could have cured her?

It behooves us all to treat carefully all of these little superficial growths of the lip until they are thoroughly destroyed. Follow the curettement with X-ray or radium and I believe you will lessen the occurrence of these extensive mutilating cancers in the majority of cases.

*Dr. Shaler Richardson, Jacksonville:*

I had the pleasure of seeing in consultation the case presented by Dr. Copp as Case No. 1.

Following the removal of the neoplasm there was considerable edema of the tissues adjacent to the removal. As a result of this there was an ectropion of the lower lid. I did a Zeigler cau-

tery puncture and after a time we got a perfect result. After a period of three or four months the condition recurred, and we did a second operation. At the time the patient left the hospital our result was satisfactory.

I think Dr. Copp and Dr. Boyd are to be congratulated on their excellent presentations. I might say that really the pictures, the lantern slides that Dr. Copp has shown you of case No. 1, do not do justice to the end result. When the patient left the hospital the lip was so perfectly reproduced that it was difficult to tell that the lip mucous membrane was not intact.

I was very much interested in watching this patient after the last operation had been performed, in his effort to smoke. For months he had been denied this pleasure and when he was given the cigar he immediately started to smoke, which speaks for itself so far as the functional end result is concerned.

*Dr. J. E. Boyd, Jacksonville (concluding):*

I am sorry that I haven't the time to answer all the questions, but I will hit on the high spots. I thank you for the frank and free discussion.

Dr. Holden spoke about the deformity resulting from operation as compared to that following the treatment by radium. I am going to take just a little bit of issue with him about that. It depends entirely upon the time that the case reaches the surgeon as to the resulting deformity. If you get them early enough, and they have not been previously treated you get no more deformity than results from radium treatment. However, Dr. Holden has had quite a large experience with the treatment of these epitheliomas both on the lip and on the face, and I have had the pleasure of hearing him read a paper on this subject. He certainly has shown some excellent results. That is one reason why I desired him to discuss this paper.

Now, I want to stress the use of the cautery. If the epithelioma has apparently gotten beyond your reach or you are going to have to do a mutilating operation, for God's sake use the cautery. When it comes to removing what looks to be a hopeless cancer you very frequently get a cure when you least expect it if you use the cautery instead of the knife. I absolutely take issue with Dr. Kirby-Smith regarding his statement, that when the adjacent glands are involved the case is hopeless. This is not borne out by my personal experience, and I don't believe that it reflects the experience of the best surgeons. I would hate to feel that every patient that comes

to me after involvement of the adjacent glands meant that I or no one else could do anything for that patient. It would be a terrible arraignment of the profession and especially the surgeon. We are doing better than that. We are not accomplishing all we would like to but we are doing better than Dr. Kirby-Smith would lead you to believe.

Dr. McEwan refers to the final result. The final result in my case was bad. I attributed this to too early plastic surgery following the radical removal. There was a recurrence about a year following the plastic. I was able to convey to him the error I had made in my case. Another error made in my case was in the untubing of the pedicle. I unintentionally severed the temporal artery and lost about half of the pedicle. Dr. Copp, as shown by the pictures, has saved 100 per cent of the pedicle in his case because he was more careful. That last picture, as Dr. Richardson says, does not do justice to the end result. The final result in his case was one of the best I have seen. Certainly it was much better than the result obtained in my case. The pictures which were shown of my case does not demonstrate the actual amount of destruction. The entire lower lip clear down to the chin was gone, and this much (demonstrating) of the upper lip on the right side. However, I feel, under the circumstances, that if he had not suffered a recurrence he would have had a satisfactory result.

I think that cancer of the lip still plays a large part in face deformities. It seems that I cannot agree with Dr. Kirby-Smith. The public is not educated to the menaces of lip sores, etc. I believe if you will just stop and think you will agree with the statement that there are yet a great many of these cases (we have had a large number in the old county hospital) where the lip, cheek and jaw were practically gone. These cases are a hell to themselves and everybody else around them. There are entirely too many seeking relief after all hope is gone.

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## FOCAL INFECTION AS RELATED TO SYSTEMIC DISEASE

ALBERT TOWER SUMMERS, M.D.,  
MIAMI, Fla.

I am most grateful for this opportunity to present a paper dealing with a very interesting and important subject, which until within the last ten years has had very little scientific considera-

tion. Not that focal infection as a cause of remote pathology is a new subject in medicine, but even to this day it is practically an untouched field of thought by the great majority of general practitioners. By this I mean that its great importance as a causative factor of systemic disease is little realized and that painstaking search is not instituted in many cases to accurately and scientifically find the source of infection in a given case.

In the short time at my disposal to present this paper the subject can be covered only in a general way. It shall be my purpose to stimulate thought in the minds of the general practitioners of medicine to such an extent that no method of scientific research will be left unused to determine the cause of a disease in a particular case and to give that case satisfactory treatment. The many cults and isms in vogue today are not without cause. The general public cannot be blamed for groping for causes of their ills. If careful study of a case is made, an accurate diagnosis arrived at and satisfactory treatment instituted, that patient will not be seeking relief at the hands of a charlatan. In order that these results may be obtained in many more cases than we find them today, the true source of infection must be found and eradicated. Observations made in the great medical clinics of this and other countries and accurate technique and scientific laboratory methods of studying hospital cases impels one to state that microorganisms found in areas of focal infection may produce pathology in almost any tissue of the body. For this reason the case must be accurately studied. In considering the areas of focal infection which are most generally conceded to produce systemic disease it is not often possible to set aside tonsils, teeth and sinuses and say that the one or the other is the one and only cause of the particular symptoms found, but a combination of these with the addition of genito-urinary conditions will account for at least seventy-five per cent or more of the cases of systemic disease. Many cases of illness originating in the tonsils or teeth are perpetuated by the intestinal tract and are then only amenable to treatment by the removal of the foci of infection and diet.

Systemic diseases of many kinds and in many parts of the human organism from infection in the tonsils, are of common occurrence.

There can be no doubt of this casual relationship of the tonsils to distant diseased conditions from the proof offered in very recent years by a



mass of clinical evidence. It is now almost universally admitted that many systemic infections arise through the entrance into the blood or lymph streams of organisms from the tonsillar crypts either with or without primary lesions in the tonsils themselves. The other method of producing disease is by the influence of the micro-organisms upon normal physiologic processes by virtue of the metabolic products elaborated in situ.

These infections have been roughly divided into two groups: first, those due to chronic conditions in the tonsils and to the absorption of organisms indigenous to the crypts; and second, those that are secondary to tonsillar lesions caused by organisms from an extraneous source, as, for example, the streptococcus infections resulting from a contaminated milk supply. Though the latter class of infections are often of a high degree of virulence and may result in fatal general sepsis or grave localized lesions, they are to be regarded rather as accidents than as due to any inherent conditions in the tonsils, beyond perhaps a general susceptibility to infection. They may be said to be of tonsillar origin only in that the infection is primary in the lymphoid nodules of the throat.

The second class of infections are due to the chronic pathological conditions in the crypts or in the tonsillar parenchyma. They alone can be directly attributed to the tonsils and for that reason they are the only infections that will be considered. It must be remembered that the other lymphoid nodules of the pharynx may be responsible for many of these infections, but that on account of the shallowness of their crypts or because of other reasons for freedom of drainage their importance in this respect is slight compared with the faucial tonsils. This is especially true of the lingual nodules.

Among the most common infections that have been attributed to this source are acute and chronic arthritis, both infectious and rheumatoid; myositis, anemia, thyroiditis, endoperi and myocarditis, acute rheumatic fever, chorea, acute and chronic nephritis, neuritis, osteomyelitis, appendicitis, peritonitis, pulmonary gangrene, infectious jaundice, cervical adenitis, of simple inflammatory or tubercular origin, and chronic toxemia without localized lesions other than those in the tonsils. Some years ago Billings and Rosenau in their study of focal infection placed the tonsil first as the most important agent

of chronic infection and more recently, quoting from Dr. Ralph Pemberton, who, with his associates, made a study of a series of one hundred cases admitted consecutively to his service on the medical wards of the Presbyterian Hospital, Philadelphia, noted the following results: Tonsil or sinus infection, 60 per cent; dental infection, 58 per cent; divided as follows: pyorrhea, 77 per cent, and infection of the apices, 46 per cent, and genito-urinary infection in 34 per cent.

The diseases found most frequently in this series of 100 cases were cardiac disease, 16 per cent; nephritis, 12 per cent; arthritis, 10 per cent. This suggests the wide range of disturbances produced by focal infection. Continuing, Dr. Pemberton cites some very interesting figures relative to a study of four hundred cases of chronic arthritis observed in army hospitals during the late war, extending over a period of seven months. The first and outstanding observation was, that the removal of focal infections from upper respiratory, genito-urinary, dental and other tracts was not always followed by a cure. The second was that a great many (46 per cent) recovered in the presence of some demonstrable focus of infection. Nearly 60 per cent of the cases followed exposure, next in frequency was dysentery and other causes, and recent acute tonsillitis was far down the list, only 3 per cent. In 27 per cent no focus could be found. Tonsillar foci of infection was demonstrated in 52 per cent, dental in 33 per cent, and genitourinary in 12 per cent, and 20 per cent showed a combination of these. Somewhat at variance with the above is an arthritic series of 123 cases reported by Holsti in which a sore throat had recently preceded the attack in 71 per cent in acute cases, 47 per cent of relapsing cases of acute arthritis and 22 per cent in chronic cases as compared to 3 per cent as reported by Dr. Pemberton. His series, however, were all men in active army service, many of them unaccustomed to exposure but now subjected to it, which increases the statistics for exposure and lessens the tonsillitic cases in comparison. From many sources come warnings to remove tonsils and adenoids in cases with ear complaints. Many cases of acute and chronic iritis clear up rapidly after the removal of the tonsils, infected teeth or the draining of an antrum. Chronic tonsillitis and not the acute form is most likely to be the underlying cause of arthritis and extreme fatigue is often a symptom of tonsil infection.



Tonsillectomy may be of some benefit in exophthalmic goitre and in my experience is very beneficial in the simple forms.

In cervical adenitis the logical procedure is to remove the tonsils and not the glands.

Tubercular infection is not very common, about 5 per cent. Holsti reports the examination of 203 tonsils from 123 persons and the finding of ten with tubercular infection, five of which were taken to be primary, the other five being associated with pulmonary lesions.

Cases of kidney involvement accompanying and following tonsillitis are frequently encountered and range from a simple albuminurias and suppurative pyelitis to a recorded case of convulsions with a blood pressure of 215 mm., which subsided and had not recurred two years after tonsillectomy. The statement was made recently that the best prophylaxis against appendicitis is the removal of infected tonsils and thereby preventing gall bladder infections. Pyorrheal pockets and infected tonsils should not be left in the mouths and throats of pregnant women until after confinement. The benefits derived from the removal of these foci far outweigh the slight shock and inconvenience attendant upon their removal at any time during the pregnancy.

With special reference to sinus disease, allow me to say that our knowledge of the etiology, symptomatology, pathology, and surgical treatment of the sinuses has increased so greatly during the last ten years that this entire paper might well have been devoted to this subject alone. It is a well-known fact that a single sinus disease very rarely occurs, two or more being commonly affected at the same time, and very often all of them on one side of the head. The maxillary is perhaps more often affected singly than either of the others, it being infected from the teeth in about one-half of the cases. The second bicuspid and the first and second molars are in close relation to the floor of the sinus and frequently project into it. Those sinuses become very rapidly diseased because of the lack of proper ventilation and drainage. Therefore the treatment of these conditions which improves ventilation and drainage is of prime importance and the removal of infectious material is secondary. To accomplish these results very often taxes to the utmost the skill of the rhinologist and the dentist. Careful history of the case, plenty of time for examination and a good skiagraph are the means to a satisfactory diagnosis. The proper treatment of

these infected areas will often give startling results in the clearing up of grave constitutional disturbances.

#### SUMMARY

Focal infections are undoubtedly the cause of a very large percentage of constitutional disorders.

These areas of infection should be removed from both the sick and the well, as a means of restoring the sick to health and as a prophylactic measure in the healthy.

More care should be exercised in locating the primary foci of infection.

An early and positive diagnosis of the patient's disease will restore to its rightful place the science of medicine in the minds of the public.

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#### TRAUMATIC CORNEAL INJURIES— WITH CASE REPORTS\*

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Normal vision being absolutely and unconditionally dependent upon a transparent cornea, our prime work in any corneal injury is to prevent any opaque condition which would interfere with the normal transparency of this tissue. Unlike an opaque lens which may be removed, the cornea must stay intact. The cornea being the window through which images of the outside world must enter the eye it is important to realize that this window may be hopelessly closed to the eye which it serves by the slightest injury. Injuries of the cornea should not be considered as trivial or insignificant. Although its purpose has been thwarted in many cases, it is the aim of Nature to equip every individual with two normal eyes in order that he may happily use them in obtaining binocular single vision.

The most frequent cause of traumatic injuries of the cornea is occasioned by small foreign bodies. The penetration of foreign bodies into the superficial layers of the cornea is a most common accident. Small particles of iron in the cornea, particularly among mechanics of a certain sort, like locksmiths, blacksmiths, iron foundries, etc., is most frequently observed. The extensive use of the carborundum wheel renders it a perpetual enemy of the eye. The saw-filer's eyes are frequently the backstop for flying par-

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\*Read before Orange County Medical Society, Orlando, Fla., April 15, 1925.

ticles of steel from the saw or file which the workman uses. In fact, it is most impossible to enumerate the varied and multiplicity of methods by which foreign bodies may produce traumatic corneal injuries. Innumerable objects under myriads of circumstances, from the innocent grain of sand or cinder from the furnace to the flying missile from a firearm may initiate disconsolate perturbation in both physician and patient.

Particles of iron which fly off from abrasive processes or when iron is being hammered, are heated by the abrasion or force of the blow so that they are thrown into the eye as sparks. These particles do not look like metallic iron for they have become oxidized into ferric oxide and are found in the cornea as such. If allowed to remain in the cornea, these fragments soon become surrounded by a brown ring, having impregnated the cells of the cornea in the immediate vicinity with ferrichydrate. If this paper does nothing more than impress the essentiality of recognizing and removing this brown ring of ferrichydrate it will have consummated no little consequential aim. You have all no doubt removed foreign bodies from the cornea, when after lifting it out you were amazed to find that there still remained, apparently, other material around where the removed object was seated. Upon the proper illumination and magnification it will be found if all the foreign body has been removed that deep in the center of the remaining mass, a white transparent spot appears. Having found this you may know that you are not dealing with foreign material, but instead the brown ring of ferrichydrate.

This ring of ferrichydrate is usually confined to Bowman's membrane which lies just under the anterior layer of epithelium and accounted for by virtue of the fact that most foreign bodies don't penetrate deeper than Bowman's membrane and that the epithelial membrane and the deep stroma seem to be more resistant to the impregnation of the iron than does Bowman's membrane.

In the event the ring of ferrichydrate is left in the cornea healing is delayed and frequently an inflammatory infiltration forms about it producing unpleasant results. If the area of discoloration occupied by the brown ring is small and the wound remains free from infection and inflammatory infiltration, regeneration of the epithelial cells may occur covering over the area of discoloration incorporating it entirely thereby produc-

ing a permanent opacity of the cornea in that area.

Corneal wounds are particularly hazardous under two circumstances, *c. g.*, when the wound is infected or when it perforates the cornea. A less frequent morbid condition, but nevertheless important, is where an opacity remains over the area of the pupil forcing the eye to deviate in or out as the case may be so that the light might fall on or as near the macula as possible. When this occurs we have a permanent strabismus resulting.

The treatment of corneal injuries is usually quite satisfactory, however, there are those cases which will tax the patience of the most resigned and indulgent of men. If the cornea has been injured by a foreign body lodging in it, it goes without saying that this object must be removed. This is usually done with the blunt spud or sharper knife, under oblique or direct illumination. For the light I personally prefer the binocular loupe which consists of a head attachment supplying illumination and magnification, leaving both hands of the operator free from having to hold lenses, etc. In removing any foreign body care should be taken not to produce additional injuries to the cornea. The anterior epithelium is easily detached and the incautious manipulation of an instrument over the cornea may denude it of a large amount of its epithelial covering.

It is important to determine, in corneal injuries, whether or not the wound is a perforating one. Every perforating wound of a cornea is to be regarded as intrinsically serious, because, given a perforation, there is the possibility of a coincident infection of the interior of the eye. Perforating or not, every corneal injury should be kept clean and free from infection and inflammatory infiltration. In view of the fact that iritis may follow corneal injuries, especially perforating wounds, the use of atrophine should not be overlooked. In perforating wounds it is best to bandage the eye after having applied a sufficient amount of 1 per cent ointment, yellow oxide of mercury, keeping the organ perfectly at rest until a solid closure of the wound is obtained. Should there be a prolapse of the iris it must be excised and see that no part of the iris remains incarcerated in the wound.

I would advise against the use of argyrol, not only in corneal injuries, but in any condition of the eye where medication is needed. Contrary to

claims, argyral does not go into solution enough to prevent it from being an irritant in the eye. Undissolved particles of argyral would influence the eye in about the same manner as an equal amount of sand.

The following case report does not relate entirely to a corneal injury, but as the cornea was involved, it is given at this juncture:

E. M.; male; age 29.

History: On March 6th, 1923, while working at a logging camp patient was hit about the face with a limb which had been thrown from a tree as the result of an impact from a moving log. Without producing other external injuries, the limb broke the patient's rimless glasses which he was wearing and in some way a piece of the broken glass produced an incised wound of the eye 9-16 of an inch in length, just at the lower margin of the corneo-scleral junction. The center of the wound opened through the cornea into the anterior chamber and each extremity of the wound penetrated through the sclera and other coverings into the fundus of the eye. The location and extent of the wound allowed a prolapse of the iris and ciliary body and the escape of the fluid in the anterior and posterior chambers and some amount of the vitreous humor. Hemorrhage prevented an examination of the fundus. No foreign material was found in the wound.

Treatment: Patient was sent to me for an enucleation, and the first impulse, after examination, was to remove the eye. Upon reconsidering the conclusion was reached that we had all to gain and nothing to lose by trying to save the eye. It was impossible to replace all of the prolapsed iris (the upper edge of the pupillary margin of iris was outside the edges of the wound). The part of the iris which could not be replaced was excised. Sutures were passed from the corneal margin over the ciliary body through the adjacent sclera, atropine was instilled in the eye and after applying a thick layer of yellow oxide of mercury ointment (1%), dressing and band-

age were applied and allowed to remain on for six days.

Result: On the sixth day when the dressing was removed it was found that the wound had united but not firmly, the anterior and posterior chambers had refilled, bringing the intra-ocular tension up to within 5mmHg. of normal, the part of the iris not excised occupied its normal position and the refractive media being quite clear. The eye remained free from infection. The suture material was removed and eye kept bandaged for several days. About three weeks after injury the wound had healed over nicely and vision without the aid of a lens was 20-40. The eye was refracted and vision made 20-20 with a minus 0.50 sphere combined with a plus 0.75 cylinder axis 180. Patient is now using eye with as good results as before the accident. No inconvenience except that a little more light is allowed to pass inside the eye as a result of the malshaped pupil caused by the iridectomy.

This case was covered under the State Compensation Act and was duly compensated for loss of time and disability sustained. Only one of three essential functions of the eye was impaired and that was the visual acuity—20-40—there being no disturbance of field or muscle function.

In estimating the disability of an organ, sustained by an injury, the Compensation Board takes into consideration the disability of the organ as it appears unaided by any mechanical appliances. For example, if an injured eye gives a *visual acuity*—obtained by showing the corresponding fractional value of the Snellen expression based on equal gradations—of 20-40 Snellen expression and fractional value of 9.10 with a value of visual acuity in percentage of 90, the Compensation Board would base its estimate on the above giving a disability of 10%, regardless of the fact that the vision may be brought up to normal by aid of a lens. They claim that the underwriters are liable for the actual disability and that if the injured can secure any mechanical aid it is left entirely with him.



# Looking Backward Over Fifty Years of Health Work in Florida

JOSEPH Y. PORTER, M.D.,  
*Former State Health Officer of Florida,*  
 1889 - 1917

*Serial No. 2.*

The yellow fever epidemic of 1888 in Jacksonville practically terminated the first of December of that year. A few cases occurred during the first part of the month, but by Christmas citizens who had fled from the city at the commencement of summer began to return and business and travel became normal again. Although the sanitary authorities of Jacksonville and of other larger eastern centers of population of the state, where yellow fever had prevailed, strenuously fumigated all houses in which cases of sickness occurred, acting on the epidemiological information held at that time, yet there was still an insistence from many that there should be a general fumigation of all homes in the city whether occupied during the prevailing sickness or had remained empty. Accordingly, an appeal was made to the Marine Hospital Service, which had rendered aid in various ways, that this request should be given consideration. Some of the readers of this narrative will remember that several years before the occurrence of events here stated, Congress had set aside annually an "emergency fund of one hundred thousand dollars" to meet just such calamities as then confronted the State of Florida. This "fund" was subject to the disposal and control of the President of the United States, to be disbursed by the Secretary of the Treasury through bureaus under his supervision and management. The Marine Hospital Service was one of the bureaus which functioned in this manner. Mr. Cleveland was then President of the United States, and authorized an expenditure of fifty thousand dollars for this purpose. A general fumigation of all dwellings in the city was made under the supervision of the writer. Dr. D. M. Echemendia of Jacksonville carried out minutely the details of the fumigation, in a painstaking manner. To this general fumigation may be credited the non-return, non-recrudescence of the fever the following year—1889. It may be asked why Jacksonville did not have a return of the fever the following year, as had been the case with Tampa the previous year. The general fumigation killed the remaining in-

fecting mosquitoes, which had not been killed by cold weather or other causes. At that time the mosquito acting as a transmitting host of the yellow fever poison was not known, and the theory was only indistinctly understood; but stumbling on the fact through an impression that the infecting principle was gaseous, accomplished a destruction of an infecting cause not then brought to light, and not until over ten years afterwards, through the investigations of Reed and his contemporaries in Cuba.

As was the case with all county boards of health then existing in Florida, funds available to combat an epidemic disease or prevent its spreading was not on hand, nor could financial aid be adequately procured locally for that purpose or at that time. An Auxiliary Sanitary Association had been organized by philanthropical citizens of Jacksonville, and from which organization an Executive Council had been created, which assumed charge of community relief work among the destitute and needy.

Col. J. J. Daniel, a prominent attorney of Jacksonville, was elected chairman, with Mr. Chas. S. Adams, also an attorney of Jacksonville, as secretary. The other members of the Executive Council or Committee were Bishop E. G. Weed of the Episcopal Diocese of Florida, and Messrs. Patrick McQuaid, Dr. John C. L'Engle, P. L. MacMurray, Peter Jones, Chief of the Fire Department; W. A. McDuff and A. W. Cockrell, Jr., an attorney.

Unfortunately, Colonel Daniel fell victim to the disease very early in the struggle. The cares and duties of chairmanship were then placed upon Mr. Patrick McQuaid, who at all time—in season and out of season—gave his time, thought and energies to relief committees. The writer, who was in Jacksonville at that period, wishes to bear tribute to the untiring and unselfish energy of Mr. McQuaid. An invalid himself, and a constant sufferer, yet there never was a time when needed that he was not ready and willing to give the help asked for. Relief committees were appointed by the auxiliary and relief sta-

tions were located in various parts of the city, from which food, medicines, and other necessities of the sick were distributed, and nurses supplied. The sympathy of the whole nation came freely to the disease sufferers, by telegrams and letters, and unstintingly by donations of money most generous in size and amount, to hundreds of thousands of dollars. The money thus donated created a fund from which the auxiliary was enabled to render efficient aid and relieve great suffering. The medical profession from elsewhere came to the assistance of their overworked brethren and fearlessly gave their services, a willing sacrifice to duty in several instances, and who, like "Jim Bludso," saw their duty a dead sure thing, and went for it there and then. Local physicians and stragglers who volunteered. All gratitude to their memory. Let a pause be here made to recall the splendid heroism of one of Jacksonville's own physicians, in 1877, during the epidemic of yellow fever in Fernandina, a neighboring city. Dr. Francis P. Welford was that year President of the State Medical Society. Against the protest of his colleagues in Jacksonville, he went to Fernandina to give of his professional skill to the sufferers, many of their own medical men being sick. He sickened and died a hero-knight, battling in the sacred armor of his profession. All honor to the memory of these men, and may their names be recorded in the Hall of Fame of the state. The writer saw probably the first definitely diagnosed case of yellow fever in Jacksonville during the summer of 1888. He happened to be in Jacksonville on a short visit of a day and was prevailed upon by Dr. Neal Mitchell, President of the Duval County Board of Health, a personal friend, to remain overnight as his guest. Before retiring to bed Dr. Mitchell had a professional call to a sick man, just across the street from his residence on Julia street, at a small hotel. On returning home Dr. Mitchell remarked that he would like the writer to see the case the next morning, in consultation with himself and the city health officer, who, if memory serves correctly, was Dr. Kennedy. Examination of the patient the next morning gave distinctive evidence of yellow fever and he was removed to the "Sand-Hills," a contagious disease camp, the next day. Cases began to crop up in different parts of the city, showing conclusively that the infective cause had existed in the city for at least two weeks, and as is now known, could only be carried from sick to well through the agency of the mosquito as a dis-

tributing host. Towards the middle of August—possibly the 10th—the writer of this article received an urgent telegraphic call from the Duval County Board of Health to come to their professional assistance, as one of their local physicians, Dr. Baldwin, had died and many others were sick. The Marine Hospital Service had established a camp for refugees, leaving Jacksonville to spend a detention period of ten days before being allowed further travel out of the state; the neighboring states insisting upon this precaution of interstate travel, to inhibit the spreading of the disease. This camp was established at the St. Marys River Line, between Florida and Georgia, a most beautifully selected and picturesque spot, in shady oaks and high banks of St. Marys River. In honor of a Governor of the state, the camp was named "Camp Perry." Assistant Surgeon John Guiteras of the Marine Hospital Service was in charge, but afterwards was relieved by Surgeon Hutton of the same service. The Marine Hospital was also aiding and assisting by payment for disinfectants and other so-called disease-suppressing measures. There arose at this time some confusion, in administration of government aid, in rendering of bills and at the request of both the County Board of Health, the Auxiliary Sanitary Association, and the Surgeon-General of the Marine Hospital Service, Dr. John B. Hamilton, the writer consented to assume charge of what was afterwards known when attaining larger proportions, the Government Relief Service. Gradually control of the volunteer professional aid and direction of nurses were assigned to this management.

The gentlemen of the auxiliary who have been mentioned, have all passed to the great beyond, and because of the charity and benevolence have doubtless received, as they deserved, the approval of the Great Master. "For as much as you have done it unto one of the least of these my brethren, you have done it unto me." Gratitude and honor to their memory, and peace to their ashes. Prominent among those of Jacksonville's citizens who rendered valiant aid to the sick both by day and at night, and to the executive duties of the city government, was D. T. Gerow, who became acting mayor during the whole period of the epidemic. Soon after yellow fever was announced as epidemic in character, the City Council became disorganized by the Mayor and several members of the city government leaving the city with their families. The few remaining members of the city government elected Mr. Gerow as Act-



ing Mayor, and thus kept together a municipal organization. A most difficult task, because a grief and disease-stricken city confronted Mr. Gerow. With a fire department decimated in number, and likewise a police department, almost a state of chaos in municipal affairs presented itself requiring constant attention, both by day as well as by night, to maintain order. It was then that the writer of these happenings, by almost hourly association with Mr. Gerow, learned to know, respect and appreciate him for the sterling qualities of character and fearlessness for personal safety, when the interests of others were concerned, meeting every demand upon his time, and discharging every obligation of duty as it arose. Nor was Mr. D. T. Gerow the only one, either man or woman, who stood during that trying time, with their back to the wall of despair, battling with an invisible foe, and with no shelter to hie to, except a consciousness of rectitude and bravery to sustain them in the fight. There were many such noble examples of bravery during that epidemic, and which it is a pleasure to make mention of.

At the close of the epidemic, Mr. Chas. S. Adams, the secretary of the Auxiliary Association, wrote and published a memoir of the work of the Association, and in a most entertaining and interesting manner entered into details of administration, tabulating also the names of those who had lost their lives in the conflict with disease that year.

When business conditions became normal and all activities connected with the epidemic had ceased, there was a call meeting at the rooms of the Chamber of Commerce, then located over the National Bank of the State of Florida, on Bay street, to hear the final report of the Auxiliary Association and to bid "good-bye" to Dr. Joseph Y. Porter, who had been practically in charge of the situation in Jacksonville since August, but more especially in connection with the financial relief given by the Marine Hospital Service. Beautiful tributes were made to those who had valiantly stood at their posts of duty and had fallen in the fray. Likewise unstinted praise to those who fighting a concealed enemy in the dark, placed service above self, and fearlessly met and conquered every obstacle which arose when the sick and needy were concerned. When the gathering was about to adjourn and many "good-byes" had been tearfully said, Mr. Schumacher

arose and, unwrapping a package, said he had been requested to give its contents to the individual to whom it was intended, but no name was given him when the package was placed in his hands. He inferred, however, from certain marks that the contents of the package was intended for Dr. Porter. On opening or unwrapping the package, a beautiful watch with heavy cable chain and charm came to view. The watch had Swiss movement, made abroad, with bell chimes striking the quarter of hour and minutes distinctive and separate in tone. The front of the double case was studded with large diamonds set as a "P" and the inside of the back of the case inscribed with name and language elegantly expressing to Dr. Porter the appreciation of the Auxiliary Association for his devotion to the people of Jacksonville during a most trying time of sickness. The chain was a heavy gold cable and the charm a miniature representation of a cork "life buoy" such as ships carry over their sterns for emergency use to passengers who were falling overboard. In the middle of one side of the charm a star in diamonds, and on the other a ruby "P." The presentation speech of Mr. Schumacher was a gem in itself, complimentary in tone, and with a ring of genuine feeling that caused many eyes to be wet from the emotion which his earnest language brought forth. Memory of that occasion even now swells the writer's heart with deep gratitude to his associates of those anxious days, with whom he was in almost hourly contact and who he learned to love and respect. Listening to what was said of him by Mr. Schumacher and others, he in reply said it appeared more to be an eulogy over his casket than what was intended for the living, and as he writes now, the perfume of flowers of esteem still lingers as fragrant as when given thirty-seven years ago. The mementoes of that occasion have been entrusted to the safekeeping of the eldest son, to be handed down by him to succeeding generations of the family. The design of the watch, chain, and charm was the thought of Mr. Joseph Crosby of Greenleaf & Crosby, now deceased. The inspiration of the charm was caught from seeing a "life buoy" on the stern of a vessel when crossing a ferry between New York City and New Jersey. It was a sentiment touchingly and beautifully expressed in an ornamental and attractive way.

*(To be Continued)*



## ENDARTERITIS OBLITERANS\*

*Report of a Case With Spontaneous Amputation of the Foot and Leg.*

HENRY E. PALMER, M.D.,  
Tallahassee, Fla.

I have no new theory as to the cause or pathology of endarteritis obliterans, nor special treatment for it. I desire to present an interesting case that came under my observation several years ago.

James Larkin, colored, male, aged 15, farmer, applied for treatment for a round ulcer located on palmar surface of right foot over the head of the first metatarsal bone. A physical examination revealed that he had endarteritis, with its usual complications, and sequelæ. I treated him several weeks without much benefit. He drifted away, and I did not see him for several months. One day as he drove by in his wagon, he raised the stump of his leg, saying, "Doctor, you were right, I lost my foot." He made the following interesting statement: "After leaving you I visited several physicians without improvement. Finally my toe turned dark, the discoloration extending to other toes, spreading over my foot, and up my leg. The pain was excruciating, and I lived on morphine, not knowing day from night for three months. One day while trying to get down the steps I fell, breaking the bone just above the dead part. The parts below were black and dead, hanging by ribbons. I asked my family to cut off the dead parts, but they refused. I took scissors, and cut the ribbons, and the leg and foot dropped off. I then began to improve and here I am." This case is interesting in showing what nature will do at times without the help of medicine or surgery. Observe the stump, how nicely it healed, never giving him any discomfort, or pain. The old man lived many years, finally dying from an intercurrent disease.

Three other similar cases have come under my observation since then. One a white, female, aged 65, suffered intense pains in her leg and foot. Finally gangrene set in, and she had a similar

experience, except the dead member hung on for months, till it almost shrivelled up, but the bone was sawn off, and she got fairly well.

The second case was a negro man about 50 years. He developed a perforating ulcer of foot, resulting in gangrene and loss of foot. The third was also a negro man about 10 who had a similar experience, ulcer, and beginning gangrene. A physician, thinking to head it off, amputated about the ankle; gangrene set in higher up, and he died very quickly.

My observation of these cases lead me to believe the best thing to do is to wait for the line of demarcation before operating.

## SPOROTRICHOSIS—CASE REPORT

SCOTT R. EDWARDS, M.D.,  
Fort Lauderdale, Fla.

An elderly woman presented herself with a skin affection of the right arm.

She gave the following history regarding this condition: Twenty-one months previous she stooped to pick up an object from the ground and at that time ran a stubble under the thumb nail. This initial lesion caused her very little discomfort, but it was very slow to heal and left a discoloration of the skin. Shortly, two lesions appeared at the base of the thumb, on its dorsal surface, followed by others along the lymphatics of the arm until at the time of examination there was a chain of scars and lesions in various stages of activity from the thumb to the axillary lymph nodes. During the elapsed period, various remedies had been tried and twenty of these small granulomata were incised.

Under sterile precautions we incised one of the lesions and cultured it on glucose-blood agar. After ten days at room temperature a typical circular growth, with marked striations, developed. Smears from these colonies showed branched mycelial filaments with typical budded spores.

Potassium iodide given internally showed a marked therapeutic result in a few weeks. However, it required several months of intermittent medication before a permanent cure was obtained.

\*Read before the Annual Meeting of the Florida Railway Surgeons' Association, St. Petersburg, May 18, 1925.

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## THE NEW VANDERBILT MEDICAL SCHOOL

The dawn of a new era of medical education is heralded in a recent bulletin issued by the medical school of Vanderbilt University. Five years ago Dr. Canby Robinson was elected dean of the school and following an extensive tour and investigation of most of the important hospitals and medical centers of the world he and his associates evolved the present unique medical school plan. Several years of intensive planning and an expenditure of over three million dollars have created the South's finest and most elab-

orately equipped center of medical instruction, which will officially open its first session in the new plant September 24, 1925. All departments of the school as well as the hospital are housed in one large building. The hospital has a capacity of 185 beds and will be devoted exclusively to teaching purposes. President-elect William D. Haggard, of the American Medical Association, in his presidential address, commented thusly on the advantages of the Vanderbilt plan:

"The new medical school of Vanderbilt University is entirely housed in the hospital, thus linking up the wards with the laboratories in an integral and intimate way. We feel that it will be a distinct gain. It will afford an unparalleled opportunity for the simultaneous study of the medical sciences and the patient. The pathologic department will be a guiding center. Fresh tissue and not merely postmortem of terminal processes will be studied. It will concentrate on the causes as well as the development of disease. With the close relation of the dispensary and the hospital, the pathologic department, where all the problems of the patient can be brought and where all the men can work as undergraduates, as interns, as residents and as members of the staff, it ought to foster a spirit of investigative interest in the patient that will be stimulating to the completest possible training."

The faculty has been entirely reorganized with the addition of many outstanding scientists of the nation as full time professors. The student body will be limited to two hundred. The school's endowment is an adequate one and the South and Nation will profit immeasurably by the work of this great institution.

## INFECTIONS FROM SWIMMING

On account of Florida's geographical location and being surrounded almost entirely by water, the problem of infections secondary to bathing and swimming should receive the most serious consideration on our part. Every summer the usual crop of otitis media and sinusitis occur where swimming and diving are most common.

Due to different opinions held by physicians, often very little advice is offered to the public. The educational campaigns put on by the State Board of Health is commendable, the assistance given by each county nurse meets with hearty approval, but the part taken by individual physicians is one of passive indifference.

Recent observations tend to confirm our belief that many bathing epidemics of otitis media are not due to infected water but to nose and throat infection. The irritation to the normal mucous membrane from forceful diving, mechanical removal of protective secretions by being in the water too long, lowered body resistance from chilling, etc., are the important etiological factors. Most open body water that is condemned is not polluted and should not be condemned until laboratory analyses have proven it. An examination of the secretions in the nose will at any time show a variety of organisms present.

Few people know how to clean the nose; they blow and puff till whatever present is lodged at the eustachian orifice or sinus opening. Relief could be obtained by having patient blow the nose, holding one side closed, or still better by drawing the secretions back into the throat. An excellent suggestion is for patients to hold the nose closed and forcibly withdraw all air (and secretions) into the nasopharynx.

Inasmuch as we are not aquatic physiologically, an appeal to use artificial protection should meet with widespread approval.

When prophylactic remedies have failed and infection has taken place it is then our duty to intelligently treat these patients, remembering the causative factors and not make light of otitis media, sinusitis, etc. There is entirely too much deafness due to indifferent advice on the part of physicians.

#### LOCAL ANESTHESIA

Surgery has shown a marked trend in the past decade toward all forms of anesthesia other than general narcosis; so much so, that it is now by no means uncommon for a patient to request local anesthesia. Experiences during the late

war proved the scope and value of local work and helped to place it in a wider field of usefulness.

Objection by busy surgeons and clinics, on the basis of the time consumed, has been largely overcome by having the trained anesthetist or assistant inject or infiltrate successive cases in advance, by the free use of pre-operative sedative hypodermic medication, and by the maintenance of absolute quiet in the surgery.

The advantages of local anesthesia have multiplied to include, not only protection to vital organs in cases suffering from damaged heart, lung or kidney, but also easier and more rapid convalescence from many operations, notably those on the eye, thyroid, chest and pleura, prostate and bladder, extremities, and in certain intra-abdominal procedures. In the hands of a trained surgeon there are practically few operations that may not be safely approached without a general anesthesia, especially when a gas anesthetist is present to cover any difficulty that should arise.

In the practice of local anesthesia a surgeon develops a respect for living tissue, a gentleness in manipulation, a technique of sharp, clean dissection and accurate hemostasis, that can but result in lessened shock and kindly healing regardless of the anesthetic he may routinely employ.

A resume of the surgical work in the past few years at the Duval County Hospital shows, among other interesting data, the growing use of "local," and may be said to indicate the trend of anesthesia in general hospitals elsewhere. Anesthetics listed under local include: regional, block, para-vertebral, trans-sacral, caudal, spinal and infiltration. It is worthy of note that ethylene came into use in this hospital in 1924 and was used that year in 111 cases.

YEAR.	OPERATIONS.	GENERAL ANESTHESIA.	LOCAL ANESTHESIA.
1919	69	58	11
1920	96	81	15
1921	178	148	30
1922	533	251	182
1923	701	370	231
1924	781	362*	419
1925 (6 months)	295	147	148

\* Of these 111 were ethylene.



## JOHN ADDISON FORDYCE.

The death of Dr. John Addison Fordyce on June 4, 1925, has deprived the medical world of an able teacher and research worker. His continued studies and investigations will go down into the annals of modern medicine as distinct contributions to the science and art of Dermatology and Syphilology.

Dr. Fordyce was born in Guernsey County, Ohio, on February 16, 1858. He studied at Adrian College, the Chicago Medical College, and the University of Berlin, receiving the degree of Doctor of Medicine from the two last named institutions, from the Chicago Medical College in 1881 and from the University of Berlin in 1888. As early as 1891 his Alma Mater, Adrian College, from which he previously received the A. B. and A. M. degrees, conferred upon him, as a recognition of outstanding service and achievement, the honorary degree of Doctor of Philosophy.

Dr. Fordyce was Professor of Dermatology and Syphilology at the College of Physicians and Surgeons of Columbia University, Special Regional Consultant of the Division of Venereal Diseases of the United States Public Health Service, Visiting Dermatologist to the New York City Hospital, and Consulting Dermatologist in the Neurological Institute, Presbyterian Hospital and Women's Hospital of New York City. He was known for his genuine and unselfish devotion to and interest in the prevention of disease and the advancement of medicine. He was ever ready to join enterprises which offered opportunities for service. In 1920 he gave a notable series of lectures, on the diagnosis and treatment of syphilis, at the Institute on Venereal Disease Control and Social Hygiene held at Washington, D. C., under the auspices of the United States Public Health Service. He was also an active member of a number of medical and scientific societies.

In 1896 Dr. Fordyce called attention to a disease affecting the mucous membrane of the lips, and consequently known as the "Fordyce Disease." This gave impetus to a further study

of this cutaneous infection by Dr. Fordyce and others, which led to its definite diagnosis and mode of treatment. He is also known for his research in quantitative studies of syphilis from a clinical and biological point of view, neurosyphilis, spinal fluid examinations, congenital syphilis, the pathology of syphilis, and dermatology.

Dr. Fordyce was a prolific medical writer. He is particularly known for his contributions to *Morrow's System of Genito-Urinary Diseases*, *Syphilology and Dermatology*, *Parker's Surgery by American authors*, and *Wood's Reference Handbook of the Medical Sciences*. He is the author of many articles in medical journals and magazines. He was editor of the *Journal of Cutaneous and Genito-Urinary Diseases* from 1888 to 1896, inclusive, leading this specialized professional journal through an important stage in its growth and development.

Dr. John Addison Fordyce will be remembered by many students as a skillful teacher and by the medical profession at large for his research contributions to a more complete knowledge and practice of Dermatology and Syphilology.

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 RECENT CANCER RESEARCH.

Daily newspapers during the past few weeks have been filled with announcements and discussions of the so-called discovery of the "cancer germ." The discovery is attributed to two English research workers, Dr. William E. Gye and Mr. J. E. Barnard. The work of these two men is heralded in most instances by the press as meaning the end of all malignant conditions the human body is heir to. Undoubtedly these men have carried on some very excellent investigations and the work that they have described in detail in the *Lancet* will add much to our knowledge of cancer. However, in an editorial appearing in the *Journal of the American Medical Association*, August 8, 1925, the medical profession is warned against becoming too enthusiastic until the hypothesis advanced by the above workers is definitely proven. The following from this edi-

torial is well worthy of quoting: "The critical reader of the reports in the *Lancet* obtains the impression that an intricate hypothesis has been developed on a small number of facts, and that if on reinvestigation by others new facts should be discovered, the hypothesis will collapse. In view of the weighty and abundant evidence that the production of cancer does not depend on or require a specific cancer germ, and that some forms of malignant growths can scarcely possibly be produced by infection (*e. g.*, complex malignant teratoid neoplasms arising in the fetus in utero), it will require much more proofs and repeated corroboration of these observations before it will be demonstrated that all cancer is caused by a 'cancer germ,' either with or without some chemical accessory agent."

In a recent pamphlet issued by The American Society for the Control of Cancer the lay-press is condemned for its sensational promulgation of information concerning the so-called cancer discovery and while they do not attempt to detract from the investigations made by Dr. Gye and Mr. Barnard, they merely advise the profession to refrain from accepting with too much enthusiasm the belief that our cancer problems have been solved. The following statement of Dr. Soper, the Managing Director of the American Society for the Control of Cancer, is embodied in this reprint: "Information given to the public by cable from England to the effect that the cause of cancer has been found in an ultramicroscopic germ should lead no one to suppose that the methods of dealing with this disease hitherto developed by the scientific world are about to be superseded. There is no reason whatever to relinquish the vigilance in seeking to discover cases of cancer in their earliest stages and in delaying the radical treatment by surgery and radiation which the foremost students of cancer have come to look upon as standard procedures.

"What has been discovered in England is apparently the causative agent of a particular kind of tumor in certain animals. This is a long way from furnishing ground for the opinion that

cancer in human beings is due to the same or a similar parasite, or, in fact, to any microorganism whatever. Still more remote is the possibility that the discovery will lead to the preparation of a specific cure for the disease called cancer.

"The best security which is afforded today against cancer lies in the earliest possible recognition of the disease and the prompt employment of skillful surgeons and radiologists."

Let us not be too hasty in accepting or rejecting the findings of the two English workers until further investigation has proven or disproven their work.

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## STATE NEWS ITEMS

*This department is supervised by Dr. Ralph N. Greene, Jacksonville. Members of the State Association are requested to forward to Dr. Greene or the Editor such news items as they may think of interest to the readers of THE JOURNAL.*

Dr. W. C. Payne of Pensacola returned from Rochester where he spent a few weeks after attending the A. M. A. in Atlantic City.

The Kiwanis Club of Pensacola conducts a free clinic at the Pensacola Hospital for the under-privileged child. Dr. C. Hutchinson, Dr. M. A. Lischkoff, Dr. Nobles and Dr. Webb constitute the medical staff. All are Kiwanians.

Dr. J. M. Hoffman, formerly of New Orleans, is now in charge of the X-ray and radium departments of the Pensacola Hospital.

Dr. Benjamin F. Barnes of the State Hospital medical staff is reported to be constructing a new type of submarine radio aerial in the bed of a gravel pit in the Flint River, Chattahoochee, from which exceptional radio broadcasting reception over great distances is expected. Incidentally, it may be mentioned that Doctor Barnes has become financially independent over his discovery of the valuable gravel pit from which material is being mined for road building in Florida. The doctor's work among the unfor-

tunate wards of the state at Chattahoochee is purely philanthropic. Unfortunately most public medical service appointments can only be filled by wealthy doctors for the love of the service and not for the meagre salaries offered.

Dr. H. W. Wade, accompanied by Mrs. Wade, the latter being an expert laboratory technician, left St. Petersburg on July 21st for post-graduate work in New York City. They will return in September.

Dr. Roscoe Knowlton and family will return to St. Petersburg shortly from an extended visit to European cities.

Dr. N. Worth Gable has entered the eye, ear, nose and throat specialty in St. Petersburg. His reception by the profession is said to have been exceptionally cordial.

Dr. A. C. Hamblin continues to occupy the position of city health officer, Tampa. Doctor Hamblin was largely responsible for the success of a number of large public health projects while he was an attache of the State Board of Health of Florida.

Dr. W. M. Ives of Lake City is said by his professional brethren to be suffering with the burdens of a new and oversized hat. The doctors of Columbia County are agreed, and unanimous in an opinion (most remarkable state of affairs among any bunch of doctors) that the cause is a nice new infant son at his home.

Dr. R. B. Harkness of Lake City will spend two weeks in Montreat, N. C., during August.

Dr. L. M. Anderson of Lake City says Doctor Bates' wife told him that every time she happened to look at a car on the Dixie Highway she saw some of the Jacksonville doctors, usually Luther Holloway or H. D. Van Schaick or Wm. J. Buck, traveling either east or west, and wants to know if the occasion of the travel is attendance upon medical society meetings or just a matter of the wealthy, traveling in indolence and luxury. Mrs. Bates, it is not wealth and the cars used are Fords rented from a local garage and the occasions are medical society meetings, or acting as best man at a wedding in Valdosta.

Senior Officer R. W. Browne of United States Veterans Bureau Hospital No. 63, Lake City, has awarded contracts for the construction of a

new mess hall to accommodate five hundred patients. One mile each of concrete roads and sidewalks are being built at this hospital. Doctor Caldwell, the clinical director of the hospital, will take special cardiological training at Boston during August and September.

Dr. Herman Watson, Orlando, has sailed for Vienna (not in the state of Georgia, but across the Atlantic) for the purpose of attending the surgical clinics there. He will return in September. Dr. C. S. Breedin of Orlando, who is now in Paris (not Kentucky, but a city in France), will join Dr. Watson in Vienna. (It is assumed by the writer of these notes that the doctors will eat much sausage and guzzle much lemonade while in Vienna.)

Dr. Robert Scherlitznauer (affectionately known by his friends as Doctor Bob) is recreating at Bennett Hall, Mackinac Island, Michigan.

Dr. Roy Webb and family of Delray, Florida, are on a vacation at Asheville, N. C. Doctor Webb writes that although he has been a member of the Palm Beach County and Florida State Medical Society for two years he has never received a copy of THE JOURNAL and wants to know how to get THE JOURNAL. (Dr. Shaler Richardson, Editor and Secretary, 111 W. Adams street, Jacksonville, Florida, please note this gouge at us and send the gentleman his JOURNAL at once or accept my resignation from writing this monthly gossip.—R. N. G.)

Dr. S. B. Strong, formerly of Florida and a member of the state society, who has for years been surgeon for a large sugar corporation of Marcane, Cuba, is visiting friends and relatives in Palatka. The Doctor contemplates returning to Florida eventually for the purpose of entering practice in this state.

Dr. John T. Hosey and family of Palatka are taking an extensive automobile trip through Alabama, Mississippi and adjoining states. They will be absent for several weeks.

Mrs. E. W. Warren, wife of Dr. E. W. Warren, Palatka, together with her sister, Mrs. S. C. Wood, wife of Dr. S. C. Wood of Leesburg, are taking a pleasure trip by automobile through Georgia, the Carolinas and the city of Washington. They will be gone two months. (Ladies of the families of Florida doctors, please note that



so long as the present management of THE JOURNAL and the money lasts you shall have your share in the items composing this news section. Send the items to me and blame the editor of THE JOURNAL if they don't appear in print.)

Dr. W. L. Hughlett of Cocoa is away on a two months' vacation in New York City. He will spend some time among the Canadian Thousand Isles. (Doctor Hughlett is strictly temperate. What a pity! what a pity!)

Dr. and Mrs. Walter Lincoln of Cocoa sailed last month from New York for a six months' stay in Europe.

Dr. and Mrs. Walter Clayton Page, Cocoa, returned last week from a month's trip to Atlanta, Richmond, Washington and Baltimore. The trip was made with no discomfort by automobile. Doctor Page has been appointed city health officer of Cocoa, vice Doctor Lincoln, resigned.

A Miami physician of prominence complains about a speed trap in the town of Taft. This town is located between Orlando and Kissimmee. No doubt Doctor Christ of Orlando will be glad to mention this complaint to his honor the Mayor when he next goes to Taft. Doctor Christ is appointed because he is athletic enough to take the chance. The complaining witness testifies that he was fined thirty dollars or twenty days for making thirty miles an hour and says there is no sidewalk crossing the highway and that he noted the presence of only two stores.

The summer medical business at Daytona has been exceptionally stimulated this summer. For the first time all three local hospitals have been kept open and are operating at full capacity. There is no epidemic in Daytona other than a large group of home-seekers coming there with well-filled purses with which to purchase homes. The doctors in Daytona have but few automobile accident cases to deal with owing to an efficient police department and a sensible traffic code.

An additional one-hundred-fifty-bed hospital is planned for Daytona.

The newest cult in Florida is the medical realtor. Realtor has for its etymological derivation the words real, meaning genuine and tor coming from the word torres, meaning bull, viz, genuine bull.

The Duval County Hospital, Jacksonville, recently constructed, will possibly be opened by January 1, 1926. The institution is exclusively for the care of the indigent sick of Duval County. Dr. John E. Boyd is president of the staff. Dr. R.

H. McGinnis is a member of the board of control. The staff organization is one of permanent personnel. At the last monthly staff meeting plans were made for the securing of an exceptionally high-class equipment, and it is apparent that the needed items will be forthcoming. Doctor Boyd spoke a few words about the future plans of the hospital.

Dr. John S. McEwan, the president-elect, left Orlando on June 9th for a three months' trip to Europe. He was accompanied by his family. He is leaving his family in a residential suburb of London while he and Doctor Halton of Sarasota make a tour of the continent, visiting medical centers of France, Germany and Austria. (This item, relating to our president, brooks of no facetious comment.)

Dr. Hewitt Johnson left Orlando June 20th for a trip of six weeks or more through the Northwest. He anticipates visiting the eye, ear, nose and throat clinics of Chicago and Rochester, Minn. During the rest of his trip he hopes to enjoy the grandeur of the Yellowstone Park.

The Orange County Medical Society is one of the live associations of the state. It is composed of the counties of Orange, Seminole and Osceola. Seminole county was created by the Legislature about eight years ago. The members of the Orange County Society who were separated by county division have continued their loyal support. Osceola joined the society last fall. The meetings are held in Orlando ten months out of the year. One meeting each year is held in Kissimmee and one in Sanford. This year the Orange County Association was well represented at the meeting of the American Medical Association at Atlantic City, Drs. G. H. Edwards, L. C. Ingram and C. D. Christ of Orlando being present. Doctor Rivers of Kissimmee and Doctor Ralph Stephens of Sanford were with the party.

Mrs. W. E. Sinclair, Miss Virginia and Master John, wife and family of Doctor Sinclair, pediatrician, Orlando, left July 10th for a visit to relatives in and around Toronto. (Toronto is in Canada.) The genial Doctor is no doubt looking upon little sufferers with a wistful sadness since the departure of his own loved ones.

Dr. Marvin Smith left last night for the North (July 20th). He will combine study with pleasure for a period of one month. He will visit Baltimore, New York and Toronto.

Miss Margaret Neal, daughter of Dr. and Mrs. T. A. Neal, recently graduated from the Beechwood School, Jenkintown, Pa. After visiting

several Eastern points, including New York and Washington, she returned to Orlando for the summer vacation period.

Capt. Wm. Munly, Medical Corps, United States Army, instructor in cardiology, school of aviation medicine, Mitchell Field, Long Island, New York, is giving to the profession of Jacksonville a series of lectures on diseases of the heart. Captain Munly was trained for a number of years under the world's greatest cardiologists, including McKensie and Lewis of England. The project is the beginning of a movement on the part of Jacksonville doctors to bring post-graduate work to one's home city, thus affording doctors who might not otherwise find it convenient to go away the opportunity of advanced medical thought. Dr. Herman H. Harris, together with Doctors Stanley Erwin and Louie Limbaugh, all specialists on internal medicine, are fostering the course.

Dr. Benjamin F. Barnes, Chattahoochee, together with his financial associate, Mr. Charles Blount, are on a tour of south Florida by auto. Doctor Barnes recently purchased large holdings near Brooksville and with Mr. Blount is planning the erection of a wooden box factory in south Florida.

The newly appointed State Board of Health held an initial meeting at Tallahassee recently. Hon. Charles H. Mann was elected president for a term of two years. Doctor Smith of Tampa and Doctor Nobles of Pensacola are the newly appointed members. Doctor Smith is one of Florida's most capable and prominent doctors. Doctor Nobles has occupied a prominent place in the profession of west Florida, is one of ability and should serve his state ably as a member of the State Board of Health. Doctor B. L. Arms, senior bacteriologist, was appointed acting health officer. Dr. Raymond C. Turck had announced that he did not desire reappointment.

Dr. C. F. Sayles, Miami, is in Europe with his family.

Dr. G. Frazer Wilson, Miami, formerly Professor of Obstetrics, Medical College of South Carolina, Charleston, died recently at Johns Hopkins Hospital, Baltimore.

According to press notices Dr. Tom Williams of Washington, D. C., has been arrested on a warrant sworn out at Miami, at which place the defendant is alleged to have practiced medicine without having a certificate from the State Board of Medical Examiners. There are many in-

stances of doctors coming into the state shortly after the state board has met and who proceed to practice under the guise of acting as assistant to some duly qualified physician. The procedure is one of evasion of the law and attorneys have expressed the opinion that the qualified doctor who thus shields one practicing without license is *particeps criminis* and subject to proceedings on the part of the state board, aimed at revocation of license.

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## STATE BOARD OF HEALTH NOTES

Some time after the adjournment of the Legislature Governor Martin announced his appointments for the State Board of Health—Mr. Chas. H. Mann, Jacksonville; Dr. H. Mason Smith, Tampa, and Dr. W. D. Nobles, Pensacola. Mr. Mann was a member of the retiring board while the other two were new appointees.

The board met at Tallahassee Saturday, July 18th, to organize, and Mr. Mann was chosen president of the board for the next two years. Governor Martin discussed the needs of health work with the members and all agreed that the continued growth of the state depends largely on the continuation of the present freedom from outbreaks of communicable diseases and the insistence that Florida shall be known throughout the country as a state that not only cares for the health of her citizens but also for the health of her visitors. On account of the great number of tourists who visit us special care must be taken to guard against the introduction of disease.

To avoid the occurrence of cases of preventable diseases the Bureau of Communicable Diseases has outlined an extensive immunization program that will be offered to all parts of the state and it is hoped that it will be freely accepted. The program includes protection against diphtheria, typhoid and smallpox and no one knows when we may be visited by the virulent type of smallpox that has been prevalent in many sections of the North in the past few years where there has been a mortality of 20 to 40 per cent of the victims.

The autoist camps are a tremendous problem in this state and they require constant supervision to keep them sanitary and safe.

Cooperating with the United States Public Health Service, there will be a thorough survey of all shell-fish areas in the state.

Governor Martin realizes the great respon-

sibility placed on the board and is heartily in accord with their plans for safeguarding the health of the people.

Due to the fact that the board desired time for

consideration as to the successor of Dr. R. C. Turck, State Health Officer, Dr. B. L. Arms of the Bureau of Laboratories was appointed acting State Health Officer from August 1, 1925.

## ABSTRACT DEPARTMENT

### SURGERY

Focal Infections in Peptic Ulcer. Haden, R. L., and Bohan, P. T. J. A. M. A., 1925, No. 1, page 409.

The authors studied a series of seventeen cases of clinical gastric or duodenal ulcer in which there was evidence of a relationship to a focal infection either dental or tonsillar. Bacteria isolated from these foci and injected into rabbits produced lesions of either the stomach or duodenum in 53 per cent of the animals while control animals injected with bacteria from foci in patients supposedly not suffering with peptic ulcers gave only 7 per cent of such lesions.

A very interesting feature was the localizing of the gastric lesions near the pyloric ring and the duodenal lesions in the upper one-third of the duodenum, the portion where free hydrochloric acid is found.

This seems to support Rosenow's contention that bacteria, especially streptococci, isolated from a foci of infection in patients having gastric ulcers or from the ulcer will almost invariably reproduce ulcers of the stomach when injected intravenously into animals. A thorough study should be made of all patients suffering with peptic ulcers and all chronic infections and suspicious foci should be removed. All dead teeth, even when showing no X-ray evidence of degeneration, may have enough bacteria to give serious trouble and therefore should be removed. They also suggest that many if not most gastro-intestinal disturbance of function are due to foci of infections too small to be demonstrated and not severe enough to cause ulceration. G. H. E.

The Progress of the Acute Appendicitis at the Boston City Hospital from 1880 to the Present Day. Dugan, D. J.

The most interesting point of this article is shown in the statistical table giving the number of cases of acute appendicitis diagnosed from 1895 to 1922 and the mortality rate per year. The increase in size of the hospital may have a bearing upon the number of cases, but the decrease in mortality from 20 per cent to 3 per cent

is a distinct credit to early diagnosis and early operation.

YEAR.	CASES.	MORTALITY PER CENT.
1895-1896	82	20.7
1896-1897	84	19.0
1897-1898	109	16.5
1898-1899	137	12.4
1899-1900	146	10.8
1900-1901	173	15.6
1901-1902	191	18.8
1902-1903	164	12.8
1903-1904	194	10.3
1904-1905	211	9.9
1905-1906	229	13.0
1906-1907	322	9.0
1907-1908	315	11.1
1908-1909	399	9.2
1909-1910	314	10.8
1910-1911	415	7.2
1911-1912	478	7.7
1912-1913	590	7.8
1913-1914	559	7.1
1914-1915	604	4.1
1915-1916	744	6.8
1916-1917	804	1.8
1917-1918	737	4.4
1918-1919	559	5.7
1919-1920	608	3.4
1920-1921	632	3.6
1921-1922	913	3.1

G. H. E.

Blood Transfusion, Its Dangers and Limited Value. Baldwin, J. F. The American Journal of Medical Sciences, July, 1925, No. 640, page 118.

Attention is called to what the author terms a recent epidemic of blood transfusions, which is passing over the country. In a review of the subject the epidemic which lasted from 1863 to 1884 is referred to. The author reviews recent literature by, and quotes from, Peterson, Crile, Lewishon, Heyd, Copher, Richard Cabot, Lee Carrington and others. There is some difference of opinion, but most of them agree on certain fundamentals.

The consensus of opinion is that blood transfusions are of major importance, and that the mortality resulting from such transfusions is much higher than is generally believed or admitted.

Blood transfusions are of no value and sometimes dangerous in cases of acute septicemia or



bacteremia. It is of no value in cases of chronic sepsis except where there is pronounced anemia. It is of no value in cases of shock except when due to severe hemorrhage.

It is unnecessary in any of the milder forms of secondary anemia. It may be of considerable value in marked secondary anemias in anticipation of operation, and in acute anemias resulting from severe hemorrhage.

The value of blood transfusion in pernicious anemia is seriously questioned. A doubt is raised as to whether life is prolonged.

In concluding he says its very great value in hemorrhage seen occasionally in new-born infants has apparently been conclusively established. It seems to be in such condition unnecessary to type the mother's blood, which can be taken at once, and the injection of a small amount into the vein of the infant, or preferably perhaps into the superior longitudinal sinus, may prove a life-saving procedure.

T. Z. C.

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Studies in Experimental Syphilis, Paper 3—Further Observations on the Possibility of Cure of Syphilis in the Rabbit with Arsphenamine. Allen M. Chesney and Harold E. Kemp from the Department of Medicine, Johns Hopkins School, Baltimore. *Journal of Experimental Medicine*, July, 1925, Vol. XLII, No. 1, page 17.

They refer to Neisser's conclusion that failure to reinoculate a syphilitic animal, whether treated or untreated, indicated the existence of the first infection, and that a successful reinoculation, on the other hand, indicated that the first infection had been eradicated. They continue their studies with a rabbit with this conclusion in mind.

Their experiments indicate that when a rabbit is treated early (41 to 50 days) that reinoculation is accomplished, the lymph node infection having been abolished. They were successful in accomplishing this in 92.3%. Of the thirteen rabbits treated 180 to 193 days after inoculation only one or 7.7% was susceptible to reinoculation. Their work indicates that the susceptibility to reinoculation depends entirely on the interval between the inoculation and the commencement of the treatment. They do not conclude from this that because the rabbit is not susceptible to reinoculation that the first infection is still present. They continue their studies further in Paper No. 4, published in the same issue of this magazine, in which this conclusion is further supported. They further interpret their findings as indicating an acquired resistance

which persists even though no trace of the first infection can be demonstrated.

T. Z. C.

### OBSTETRICS.

Responsibility of the Medical Profession in Further Reducing Maternal Mortality. Austin Flint, M.D., *American Journal of Obstetrics and Gynecology*. Vol. IX, page 864. June, 1925.

The first and most important factor in reducing maternal mortality is more thorough education of the undergraduate student. The average medical student can not always be made an obstetric specialist, but he can be given more drilling in the so-called normal cases. Unwarranted interference in the course of normal labor causes many of the complications that result in invalidism and actual death.

During the past few years clinical methods of instruction in obstetrics have increased in importance and didactic methods have become relatively unimportant. Other changes in methods of teaching are mentioned and a detailed account of a student's training given.

Maternal mortality will be reduced as soon as operative deliveries are taken out of the hands of the incompetent and sent to maternity hospitals. There should be more of these special maternity hospitals, both for the benefit to the patients and for the better training of medical students and nurses. General public is demanding obstetrical specialists more and more. Obstetrics should be invested with greater dignity and better paid; the general public should be taught to adequately appreciate such services. Thus better men would be attracted to this branch and the present mortality correspondingly decreased.

Labor is not a normal function under modern conditions. More than twenty-five thousand women die from childbirth annually in the United States. At least a quarter of all women that undergo labor are more or less invalided and suffer unnecessary pain. Three to seven per cent of all babies are killed.

The author then discusses the modern treatment of sepsis, eclampsia and hemorrhage, which are the cause of a large proportion of the deaths. Sepsis is preventable in a large measure and better results would follow the establishment of more special hospitals and a better aseptic technic.

Eclampsia is preventable and can be almost eliminated by establishment of more prenatal clinics and by better prenatal supervision among private patients. We would also improve our

statistics by the adoption of a more conservative method of treatment.

In hemorrhage all precautions must be taken to prevent it. Induction of labor is the most frequent cause of death from this source. High forceps should never be attempted except by an expert. Other forceps operations are performed too frequently.

Cesarean sections are done too freely or for insufficient indications. In the best of hands it carries a mortality of from two to five per cent. The routine application of forceps in normal cases is a source of danger because too many consider themselves sufficiently expert and cause serious injury instead of preventing. The same applies to the routine version.

In short, less operating, more conservatism is the chief remedy for the present high mortality. Education of the medical student, education of the medical men not now expert, education of the public to demand better service, and willingness to pay for it, the establishment of more special hospitals, will go far towards accomplishing this desired result.

S. R. N.

#### OPHTHALMOLOGY.

Tower Skull, Oxycephalus. Frederick A. Davis, M.D., *American Journal of Ophthalmology*. July, 1925. Vol. 8, No. 7, page 513.

The author defines the condition as follows: Briefly the condition might be described as a congenital malformation of the skull of unknown origin, perhaps developmental, due to premature synostosis or fusion of certain sutures of the base and vault, characterized by a high, pointed or dome-shaped configuration of the skull, accompanied by exophthalmos of varying degrees, and marked reduction in vision due to secondary optic atrophy. The disease was first described by von Graefe in 1866, and later more thoroughly by Michel in 1873, who definitely associated optic atrophy with cranial deformity.

Under symptoms and physical signs the following are listed:

1. Impairment of vision due to optic atrophy.
2. Exophthalmos.
3. Strabismus.
4. Nystagmus.
5. Skull deformity.
6. Headache.
7. Convulsions.

Impairment of vision varies from a mild amblyopia to a complete amaurosis as a result of

optic atrophy. Exophthalmos is the most common physical sign observed, occurring in ninety-eight of the ninety-nine case histories reviewed. Skull deformity varies from a merely tall head to the more typical findings, namely:

High dome-shape or pointed skull; high forehead.

Short antero-posterior diameter (typical severe type).

Widening or bulging temporal fossæ (typical severe type).

Flattened cheek bones.

Feebly marked superciliary ridges.

Shallow orbits.

Prognathism (mild cases).

High, narrow palatal arch.

Deviation of nasal septum.

Obliteration of sutures, thickenings or depressions.

Crista Sagittalis—prominent ridge along anterior portion sagittal suture (mentioned by many authors, not present in cases herewith reported).

Asymmetry of face.

X-ray findings are among the most interesting changes found and form one of the striking and important points in the diagnosis.

The more typical radiographic findings show thinning of the skull, together with depressions and ridges, or the so-called digital impressions. These are seen over a large portion of the cortex, often throughout. The skull appears honey-combed, the depressions conforming to the underlying convolutions. These depressions are attributed by most authors to the pressure of the underlying convolutions in a skull unable to expand due to suture closure. Vessel markings are exaggerated. The base of the skull also shows the result of this craniostenosis, as the middle fossa is often pushed down near the level of the posterior fossa and the anterior fossa is shortened and distorted. The frontal sinuses are obliterated in extreme cases. Obliteration of ethmoids has also been noted. The shallow orbits can be plainly seen. There may be a definite protrusion at the anterior fontanel and at times an actual break in the skull and protrusion of brain; a spontaneous decompression.

Suture obliteration is usually seen. The sella may be clearly outlined. It may be widened and displaced backward. (Fletcher.)

The author reports in detail six cases coming under his observation in the department of oph-

thalmology in the University of Wisconsin. The conditions occur much more frequently than is generally believed. In order to differentiate this condition from congenital idiocy the case of the latter condition is reported for contrast. This condition has been ascribed to rickets and meningitis, but the author believes it to be essentially a fault of development.

S. A. R.

#### DERMATOLOGY.

Dermatitis Produced by the Portuguese Man-of-War. E. D. Crutchfield, M.D. Archives of Dermatology and Syphilis, Vol. XII, No. 1, page 72, 1925.

Crutchfield's report of a dermatitis from contact with the Portuguese Man-of-War in the July number of the Archives is interesting to readers of the FLORIDA STATE MEDICAL JOURNAL, especially at this time of the year when it is not an uncommon occurrence for bathers at the Florida ocean beaches to develop this painful dermatitis. The following summary of the article:

1. The tentacles of the Portuguese Man-of-War contain an irritant substance capable of producing an acute dermatitis.
2. The dermatitis varies from an urticarial line to a linear coagulation necrosis, varying with time of contact.
3. The acute symptoms of the disease are alleviated by the application of weak antacid solutions.
4. The lesions heal, leaving a hematogenous pigment, which is slowly absorbed. In some instances, healing is followed by permanent scar formation.

J. L. K.-S.

#### ROENTGENOLOGY.

The Clinical Importance of Chronic Changes in the Appendix. Franklin W. White, M.D. The American Journal of Roentgenology and Radium Therapy, January, 1925, page 12.

The term "Chronic Appendix" is a poor one. There are practically no chronic inflammations in the appendix with the rare exception of tuberculosis. There are many chronic changes resulting from previous or recurrent inflammations such as scar tissue, fibrosis, adhesions, and obliterative changes.

The roentgenologist has a heavy responsibility when he makes a diagnosis of "chronic appendix," as this is frequently equivalent to saying to the family doctor or surgeon, "take it out." Clinical experience has shown that we should be slow in diagnosing chronic appendicitis as a cause of digestive symptoms unless there is a clear history of previous acute or recurrent at-

tacks and no other cause is found for the digestive disturbance.

Graphic roentgen evidence is striking and makes a great impression. The signs are divided into two classes, the direct and indirect. The direct roentgen signs of chronic changes in the appendix can be listed as follows:

Tenderness, fixation, kinking, changes in shape and position, lack of filling, slow emptying, beading and adhesions.

The indirect signs are pyloric spasm, ileal stasis, and, rarely, gastric residue. These signs are merely suggestive, several being necessary for diagnosis.

The examination of the appendix is usually part of a complete gastro-intestinal examination, and the appendix may be filled at the end of six hours, but at this time it is often covered by coils of ileum, and not easily seen. The best time for examination is from 12 hours onward after the ileum is empty. It may be necessary to follow the patient for two days or more, to see if there is delay in emptying the appendix. The normal appendix empties usually in a day or two, and, occasionally, not for three or four days; but it is always suspicious when an appendix remains filled for a day or two after the cecum is empty, especially if any of the signs are present such as tenderness, narrowing, or fixation.

Tenderness is the best single sign of pathology, operation rarely being made if there is no tenderness when the appendix itself is moved under the palpating finger or spoon when filled. This definite tenderness of a visible appendix is a far more valuable sign than tenderness over McBurney's point, which may be over the appendix or five or six inches from it. Appendices that do not fill on youth or middle aged patients are suspicious of pathology. Practically all pathologists agree that obliteration is a sign of disease and is due to repeated deposits of scar tissue. Segmentation, or beading, does not necessarily mean disease as it probably results from a tonic constriction, or a drying out and a separation of the contents of the appendix. Fixation is important and is usually due to adhesions. Changes in the shape and position have slight bearing on the health of the appendix.

The roentgen examination of the appendix is a very delicate method. It discovers many things which were unsuspected, and incidentally many things which may trouble the patient very little,



such as, poor mobility, small fecal masses, peculiar shapes, obliteration of the lumen, beading, and moderate delay in emptying. No organ is so often removed without cause because of some anatomical changes.

Finally, the diagnosis of chronic appendix should be made only in connection with clinical history, those cases having the appendix removed without a history of acute or recurrent attacks are usually followed by a continuance of their digestive symptoms. W. McL. S.

### OTO-LARYNGOLOGY

Recognition of Sinus Disease in Children. Roy M. Barlow, M.D. *Annals of Oto-Laryngology*, June, 1925.

With fitting tribute to Dean and Byfield for their investigations of sinus disease in children, Barlow immediately draws the analogy of "chronic colds" and sinusitis as seen in children.

Believing large numbers of children in the past have had unrecognized infections of the paranasal sinuses he pleads for closer observations on all cases of "chronic colds" and impresses the fact of the extent of sinus development in the young, mentioning the presence of antrum in infants aged 6 months and ethmoids at 12 months and frontals at 3 to 4 years, believing lack of this knowledge of anatomy explains past errors in diagnosis.

Affections of adult life as hay-fever, asthma, polyp formations are reasonable sequelæ of sinus disease in child life.

Chorea, arthritis, iritis, nephritis are in many cases focal symptoms of the local disease in childhood.

If the child uses many handkerchiefs during the day, has a muco-purulent nasal discharge, a vestibulitis, excoriation of the nares with a secondary pharyngitis or laryngitis and possibly a bronchitis with enlargement of the anterior cervical nodes, the suspicion is of the sinuses and symptomatic treatment directed elsewhere will avail little.

Barlow believes the X-ray an aid in diagnosis. In the treatment he says local medication is unsatisfactory except in acute cases. In subacute or chronic pathology surgery is indicated.

J. L. B.

### AMERICAN BOARD OF OTOLARYNGOLOGY

An examination was held by the American Board of Otolaryngology on May 26, 1925, at the Medico-Chirurgical Hospital, Philadelphia, with the following result:

Passed .....	137
Failed .....	20
<hr/>	
Total examined .....	157

The next examination will be held at the University of Illinois School of Medicine on October 19, 1925. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Missouri.

### DALLAS WILL ENTERTAIN THE SOUTHERN MEDICAL ASSOCIATION IN NOVEMBER

A warm invitation is being extended to the doctors of the South to attend the annual meeting this fall, and preparations are being made to entertain between four and five thousand. Already 1,500 rooms in the best hotels have been set aside for this purpose, and it is estimated that more will be available.

Dallas has all the chief requirements for a successful convention city; ample hotels and auditoriums, accessibility, facilities for entertainment and diversion, coupled with whole-hearted hospitality on the part of the citizenship. It is not only a medical center of importance, but a city of interest and opportunity.

#### EASILY ACCESSIBLE

Ten trunk line steam railroads serve Dallas, with 100 passenger trains daily in and out of the \$6,500,000 Union Terminal Station, 258 inter-urban trains leave the \$1,000,000 electric inter-urban station daily. Dallas is 16 hours by rail from Kansas City, 18 hours from St. Louis, 27 hours from Chicago or Cincinnati, and 43 hours from New York.

For those who wish to use the automobile in attending the S. M. A. convention, Dallas is located on five transcontinental highways, Bankhead, Meridian, King of Trails, Dallas-Canadian-Denver, and the Dixie Overland. These highway organizations assure the tourist of well-kept roads. In Dallas County alone are a thousand miles of surfaced highways, and a tourist camp and centers of highway information are available also.

#### CLUBS, RESTAURANTS, THEATRICAL FACILITIES.

Dallas has a number of strong clubs, splendidly housed, such as the Dallas Athletic Club, University Club, City Club, a number of fine golf clubs, and all the leading national service organizations, such as Rotary, Lions, Kiwanis are represented here—all are most hospitable in the entertainment of visitors.

Restaurants, either connected with hotels or independent, are numerous and of a generally high standard. Some of the highest priced chefs in the nation are here. You can get meals with a Western flavor, Mexican dishes, Chinese dishes, or old-fashioned Southern cooking. All-the-year truck gardens and farms are producing in some part of Texas, and this coupled with proximity to packing houses, poultry farms and orchards, tends to keep food prices reasonable.

Dallas has 37 theaters, with a combined seating capacity of 28,000. These include summer and winter stock companies, many good road shows during the season, high-class vaudeville and motion picture houses, and the Little Theater which was twice awarded the Belasco prize. There are theaters costing as much as \$2,000,000 and seating as many as 3,000 persons.

#### CLIMATIC CONDITIONS

Dallas' climate as a whole is pleasant and invigorating, without severe extremes, and November in Texas as a rule is crisp and clear, ideal for travel and for outdoor sports.

Through the medium of this JOURNAL, in later issues, data on the hospital and clinical facilities of the Convention City will be given, meanwhile, the medical profession of Dallas and of Texas, invites you to plan to attend the Southern Medical Convention this fall.

### TRUTH ABOUT MEDICINES

#### NEW AND NONOFFICIAL REMEDIES

**SCARLETINAL ANTITOXIN (Unconcentrated)**—MULFORD.—A scarlet fever streptococcus antitoxin (*Jour. A. M. A.*, May 2, 1925, p. 1338). It is prepared from the serum of horses treated with subcutaneous injections of toxic filtrate from cultures of scarlet fever streptococci and also with intravenous injections of the streptococci themselves. Each cc. neutralizes at least 10,000 skin test doses of scarlet fever toxin. Marketed in packages of one syringe containing 10 cc. (prophylactic dose) and in packages of one vial containing 40 cc. (therapeutic dose). H. K. Mulford Company, Philadelphia.

**SCARLET FEVER ANTITOXIN-LEDERLE (Unconcentrated)**.—A scarlet fever streptococcus antitoxin (*Jour. A. M. A.*, May 2, 1925, p. 1338). It is prepared by immunizing horses by the subcutaneous injection of the toxic filtrate obtained by growing the scarlet fever streptococcus in broth; also by injection of cultures of the scarlet fever streptococcus. Each cc. neutralizes at least

10,000 skin test doses of scarlet fever toxin. Marketed in packages of one syringe containing 10 cc. and in packages of one cylinder containing 50 cc. with an intravenous injection outfit. Lederle Antitoxin Laboratories, New York.

**INSULIN—STEARNS 80 UNITS, 5 cc.**—Each cc. contains 80 units of insulin—Stearns (New and Nonofficial Remedies, 1925, p. 174). Frederick Stearns & Co., Detroit.

**INSULIN-STEARNS 80 UNITS, 10 cc.**—Each cc. contains 80 units of insulin—Stearns (New and Nonofficial Remedies, 1925, p. 174). Frederick Stearns & Co., Detroit.

**TUNA FISH PROTEIN EXTRACT DIAGNOSTIC-P. D. & Co.**—A protein extract diagnostic-P. D. & Co. (New and Nonofficial Remedies, 1925, p. 289). Parke, Davis & Co., Detroit. (*Jour. A. M. A.*, July 4, 1925, p. 35).

**LOEFLUND'S MALT EXTRACT.**—A preparation essentially similar to extract of malt U. S. P. It is marketed as Loefflund's malt extract with calcium (containing calcium lactophosphate 0.5 per cent) and Loefflund's malt extract with cod liver oil (Norwegian cod liver oil 33 per cent). Britt, Loeffler & Weil, New York, distributor. (*Jour. A. M. A.*, July 11, 1925, p. 115).

**NEOSALVARSAN DOSE XII.**—Each tube contains neosalvarsan (New and Nonofficial Remedies, 1925, p. 50), 1.8 gm. H. A. Metz Laboratories, Inc., New York.

**SCHICK TEST-LILLY.**—Diphtheria Immunity Test (Schick Test), (New and Nonofficial Remedies, 1925, p. 50), is also marketed in packages of two vials, one containing diphtheria toxin sufficient for fifty tests and the other vial containing the proper amount of diluent. Eli Lilly & Co., Indianapolis. (*Jour. A. M. A.*, July 25, 1925, p. 269).

#### PROPAGANDA FOR REFORM

**LISTERINE.**—So far as the composition is concerned, the use of Listerine as a simple mouth wash is unobjectionable. Unfortunately the manufacturers are not content to recommend and advise it exclusively for the field in which it has a place. Listerine is exploited with an air of conservatism, even a statement of composition is given which, however, is essentially meaningless. While the claims as to antiseptic efficiency and the claim that it is a deodorant (it is not a deodorant, but merely covers one smell with another) may in general do little harm when Listerine is used as a "toilet preparation," the advertising that accompanies trade packages

contains recommendations for its use in serious conditions, the self-treatment of which is a danger to the individual and inimical to the public health. The potency for harm that these recommendations have is all the greater because the manufacturers affirm that they "do not advocate self-medication, even with Listerine." The trade package circular recommends the use of Listerine in "tonsillitis"; this may easily lead to its employment in undiagnosed cases of diphtheria, and dependence on it in such conditions may be the means of spreading this infective disease. The circular suggests its use in "bronchitis," which may be tuberculosis or pneumonia. It recommends its use in "leucorrhea"; this may lead to the self-treatment of a serious infection. The self-treatment of any such conditions is fraught with danger to the individual and to the community. (*Jour. A. M. A.*, July 4, 1925, p. 55).

**TREATMENT OF SNAKE-BITE.**—The indications for the treatment of snake-bite are the same as those for any other kind of poisoning: namely, first to remove the poison, secondly, to remove its effects. Immediate interruption of absorption should be attempted by application of a bandage for a period. Removal of the poison from the wound after having enlarged it, by sucking, by washing, or by destruction by red heat or a caustic is the next thing to attempt. The third, most important remedy, is the injection of antivenom serum, which must be specific for the particular venom involved. (*Jour. A. M. A.*, July 4, 1925, p. 57).

**THE PARATHYROID HORMONE.**—The significance of a hormone elaborated by the parathyroid structures for the metabolism of calcium, at least so far as the relation of the content of this element in the blood is concerned, seems to be well established. The promise of preparing an effective parathyroid product seems about to be fulfilled in various places. The publications of Hanson in 1923 show that he was actively engaged in the extraction of an active product. Since then success had attended the investigation of Fisher and Larson and particularly those of Collip. Both Collip and Fisher and Hanson warn against the possible dangers of unwarranted therapy with potent preparation, for symptoms of atonia depression, diarrhea and dyspnea are readily produced by large doses of a potent preparation. (*Jour. A. M. A.*, July 11, 1925, p. 118.)

**THE QUANTITATIVE ACCURACY OF MEDICAL**

**TABLETS.**—Attention has been called repeatedly to discrepancy between the actual composition and the claims made for various tablets and pills sold to the medical profession. Variations as high as 54 per cent above and 10 per cent below the label statement of composition has been found. Two associations of pharmaceutical manufacturers have appointed a joint committee which collaborates with the government authorities in an attempt to bring about improved conditions. During the past years, attention has been given by this group to the composition of hypodermic tablets. As a result of this study, plans for controlling the degree of accuracy of hypodermic tablets have been issued by the federal Bureau of Chemistry in which is given a maximal permissible variation, ranging from 7.5 to 9 per cent. The fact that the pharmaceutical industry collaborates with the governmental authorities in the establishment of standards is encouraging. (*Jour. A. M. A.*, July 11, 1925, p. 118.)

**RHEUMEEZ NOT ACCEPTED FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that "Rheumeez" (Casco Laboratories, Elizabeth, N. J.) is claimed to be magnesium cinchophen, the magnesium salt of 2-phenyl-quinolin-4-carboxylic acid. From the advertising issued for the product, one gets the impression that the production of the magnesium salt of cinchophen is a noteworthy achievement on the part of the Casco Laboratories and that the product is superior to cinchophen. However, this compound is the analogue of the well-known cinchophen-sodium. When a solution of Rheumeez is treated with dilute hydrochloric acid, cinchophen is precipitated; therefore the compound will be decomposed in the gastric fluid of the stomach and its administration will be equivalent to the administration of cinchophen accompanied by an insignificant amount of magnesium. The council found Rheumeez unacceptable because (1) it is an unessential modification of the established drug cinchophen; (2) it is marketed under a nondescriptive therapeutically suggestive name; and (3) it is advertised with unwarranted and misleading claims which will lead the public to attempt self-medication in conditions which require the diagnosis and supervision of physicians. (*Jour. A. M. A.*, July 11, 1925, p. 132.)

**PREVENTION OF MOSQUITO BITES.**—Numerous preparations have been proposed to be applied to exposed parts of the body to prevent mosquitos from biting. Among these are oil of



pennyroyal, resorcin monoacetate euresol, various forms of petroleum, and powders and washes similar to the following: oil of eucalyptus 25 cc., talc 50 gm., starch 325 gm., oil of cinnamon 1 cc., oil of patchouli 1 cc., oil of santal 4 cc., alcohol to make 400 cc. (*Jour. A. M. A.*, July 11, 1925, p. 134.)

**THE WILKENS-FIRST CANCER CURE.**—During the last ten years literature has been sent out by an illiterate advertising cancer quack, one J. K. Wilkens of Muscatine, Iowa. Apparently it is an escarotic paste. Some years ago it was stated that this treatment had been endorsed by Dr. F. H. First and used in a hospital in Rock Island. Dr. First admitted that he was using the preparation. Dr. First was asked to disclose to the medical profession the composition of the preparation which he was using. He replied that, until such time as he could "report on a list of cured cases," he could "see no reason to make the treatment public." This was in 1917, but Dr. First does not appear to have reported the list of cured cases nor given the profession the formula. (*Jour. A. M. A.*, July 11, 1925, p. 135.)

**LOWERING THE BLOOD PRESSURE WITH LIVER EXTRACT.**—The effect of liver extract administration on blood pressure was studied in thirty-three cases. In these cases hypertension had persisted for varying periods. Physiological sodium chloride solution of extract of the liver was injected intravenously. Twenty-five patients experienced no disagreeable symptoms, most of them reported apparent relief. In eight cases there were reactions of varying degree, some of which resembled protein shock. There was an average fall in the systolic pressure of 62 mm., and an average fall in diastolic pressure of 28 mm. Investigations are under way to determine the constituent or constituents of liver responsible for the effect on blood pressure. The clinical value of liver extracts will depend, not only on the development of a stable and uniform extract, but also on the permanence of the fall in pressure and its relation to other pathologic changes existing in the body. (*Jour. A. M. A.*, July 18, 1925, p. 194.)

**MIZAR.**—Mr. Sorokowski, formerly of Chicago and now apparently operating from a suburb, Oak Park, sells, "especially to the foreign element," a product that he calls "Mizar" as "the most effective remedy for rheumatism." Mizar comes in the form of an ointment. Two cases of dermatitis venenata from its use have been re-

ported. The A. M. A. Chemical Laboratory examined Mizar and reports that the preparation may be considered essentially an ointment, the chief active ingredient of which is an extract of capsicum. Presumably a product of this sort appeals to those purchasers of "patent medicines" who feel that they are not getting their money's worth unless the preparation has an appalling smell or taste, or produces some physiologic reaction that will make them sit up and take notice. (*Jour. A. M. A.*, July 18, 1925, p. 212.)

**ADMINISTRATION OF HEXAMETHYLENAMIN.**—In a solution containing hexamethylenamin 3 gm., acid sodium phosphate 9 gm. and distilled water 120 cc. a faint reaction for free formaldehyde is obtainable, though the reaction is much less intense than that obtained in a solution of the same amount of hexamethylenamin in 0.2 per cent hydrochloric acid. In the course of days when kept at ordinary room temperature and in diffused light the formaldehyde reaction in the solution increases. When recently prepared the acid sodium phosphate-hexamethylenamin mixture is not objectionable; however, in view of the comparative instability of the mixture it is advisable, either as Useful Drugs recommends, to administer acid sodium phosphate midway between the doses of hexamethylenamin or else to add hexamethylenamin to a solution of acid sodium phosphate just before administration. (*Jour. A. M. A.*, July 18, 1925, p. 214.)

**SODIUM IODID IN ASTHMA.**—The use of iodids as adjuvants in the treatment of asthma seems to be of such general acceptance that recent medical literature reveals few special studies of its effects in this condition. The intravenous administration of sodium iodid in this condition has been reported. However, a report on the intravenous administration of sodium iodid in the Mayo Clinic states that there is no advantage in using sodium iodid intravenously, except in a few cases where massive doses might cause iodism. The Council on Pharmacy and Chemistry does not endorse the routine administration intravenously of sodium iodid. The Council holds that intravenous medication generally is not as safe as oral administration, and further, that there is little if any justification for the intravenous administration of such agents as sodium iodid, because their systemic effects are promptly obtained from oral administration. (*Jour. A. M. A.*, July 25, 1925, p. 290.)

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# THE PREVENTION OF HYDROPHOBIA (RABIES)



OF LATE a great many cases of rabies in dogs have been reported from various parts of the United States. These reports show that the infection is widely distributed. No section of the country is entirely free from rabies. The dog, from the very nature of his habits, is the main disseminator of this disease.

The physician is called on today as never before to guard his patients against rabies. Only one form of treatment is available—*preventive vaccination* before the appearance of symptoms.

Whitmore (Tice, Practice of Medicine) lists the conditions calling for antirabic vaccination after a dog bite, as follows:

1. If rabies is in the district, antirabic vaccination should be started at once and continued until the dog can be observed for ten days.
2. If the dog dies or is killed or disappears in less than ten days after biting the patient.
3. If the dog is unknown.
4. If the dog is living and after observation for ten days develops rabies, dies under suspicious circumstances, or is sick.

Rabies Vaccine (Cumming), prepared in the Biological Laboratories of Parke, Davis & Co., is a sterile suspension of brain tissue from rabbits killed with fixed virus (death with paralysis in seven days). The infectivity is removed by dialysis, while the full immunizing properties are retained. No report of injurious results to the patient following treatment has ever been received.

Few specific prophylactic agents present a record for dependability comparable to that attained by Rabies Vaccine (Cumming). During the many years that Rabies Vaccine (Cumming) has been supplied to the medical profession, not one complaint of distinct failure relating to this product has ever reached the Laboratories. Considering the many thousands of patients treated with Rabies Vaccine (Cumming), this is a truly remarkable record.

*The Vaccine is obtainable on short notice by all druggists, being carried in stock under proper conditions for its preservation, by the home laboratory and our branches.*

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# THE JOURNAL

— OF THE —

## Florida Medical Association

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## THE X-RAY DIAGNOSIS OF GALL-BLADDER DISEASE—CHOLECYSTOGRAPHY AFTER INTRAVENOUS DYE INJECTION.

J. A. BEALS, M.D.,

Jacksonville, Florida.

The correct diagnosis of gall-bladder disease, as proven by operation is a notoriously difficult problem.

It was only after the development of modern apparatus of precision, allowing fractional seconds of exposure, that X-ray findings became really valuable adjuncts to the diagnosis.

The modern technical improvements primarily stimulated the X-ray studies of gastric, duodenal and colonic lesions with the bismuth or barium mixtures. As a result most clinicians now accord the roentgenologists' report, relative to these organs, a measure of deserved confidence. The findings of definite shadows of gall-stones has been accepted with like confidence, but the failure to find them was soon discovered to have little exclusion value. Probably less than forty per cent are demonstrable.

It was this failure of the X-ray to be of material assistance in all but a limited number of patients with gall-bladder disease which lead certain workers, notably George and Leonard, Kirklin, Burnham, and Arens,<sup>1</sup> to search the gastro-intestinal tract for signs occurring with some diagnostic degree of regularity. The works chiefly of these men have established a number of so-called indirect signs of gall-bladder disease.

A thorough study of the gastro-intestinal tract, with opaque meal and enema, which fails to disclose any lesion of stomach, duodenum, or colon, constitutes perhaps the most reliable indirect evidence of gall-bladder disease, provided functional disturbances are excluded.

If any of the other indirect signs are present the diagnosis is strengthened. Several such signs have been advanced. Some of the more frequently occurring are as follows:

(1) A concave or crescentic depression of the contour of the pyloric portion of the stomach or

duodenal bulb, or deflection of the distal duodenum, presumably due to deforming pressure of a distended or inelastic gall-bladder.

(2) Spasm of the pyloric portion of the stomach, sometimes narrowing the lumen to a mere slit, and often associated with regurgitation into the esophagus.

(3) Stasis, with to and fro movements of the barium meal in the distal segments of the duodenum.

Less frequent signs are: (a) filling of the ampula of Vater with the barium mixture; (b) demonstrable adhesions which fix or deform the stomach, duodenum or hepatic flexure of the colon; (c) a pressure-pain point in the upper right quadrant which is not located over the stomach, duodenum or colon.

Slight mention has been made in the literature of the frequent occurrence of filling defects which deform the stomach and duodenal bulb, often persisting until belladonna has been administered to physiologic effect. This appearance is doubtless due to a reflex spasm arising almost anywhere outside the stomach or duodenum, but in my experience has been most marked in patients proven to operation to have a diseased gall-bladder.

These indirect signs rest upon logical theory, experiment, and clinical proof. They are not equally valued, or even accepted, by all roentgenologists. The scope of this paper is too broad to discuss their separate worth or limitations. In my own experience they have proven very valuable in corroborating a clinical diagnosis, and occasionally of sufficient importance to influence a difficult differential diagnosis, but when considered entirely alone they are apt to be misleading, and result in embarrassment. If carefully sought some of them will be found in nearly all proven patients with gall-bladder disease, but they also occur in other conditions, and at times are lacking or overlooked when disease of the gall-bladder is present.

A direct sign of gall-bladder disease is, of course, the visualized stone. George and Leonard of Boston have been foremost in advancing the belief that when the gall-bladder itself can be projected upon the X-ray film, such finding constitutes an equally dependable direct sign of dis-

<sup>1</sup>Arens, R. A.: Gall-bladder Disease with Special Reference to Fluoroscopic Findings. *The Journal of Radiology* IV; 274, August, 1923.



ease. According to Leonard,<sup>2</sup> direct evidence alone is demonstrable in about one-third of these patients.

Such a broad conclusion has led to considerable controversy and expression of doubt, so that one not infrequently reads statements such as those of:

Hirsch,<sup>3</sup> who says, "I am sure that with careful technique and at a favorable moment, a normal gall-bladder may be demonstrated in a large majority of individuals."

My feeling on this question is one of skepticism, after having conservative surgeons operate on some of those patients, in which the shadow has been clearly demonstrated, for not always has the surgeon seen fit to operate on the gall-bladder, and sometimes a most diseased gall-bladder has failed to cast a shadow.

Apparently the number of patients presenting this finding is proportional to (a) the shortness of exposure time, (b) the lowest penetration allowable, (c) adequacy of the patient's preparation, and (d) the number of films exposed. The finding is not valueless, however, for, with our present technique, considerably more diseased than normal gall-bladders are projected.

A new method for the X-ray examination of the gall-bladder which appears to hold greater promise of accuracy than former methods, was published by Graham and Cole,<sup>4</sup> in February, 1924. The new method consists essentially in the intravenous injection of a chemical which is excreted by the liver and accumulated for a time in the reservoir of the gall-bladder. The substances used so far have belonged to the group of dyes containing iodine or bromin, the high atomic weight of which permits the projection of a fairly distinct shadow of the gall-bladder.

The dye most generally used at present, the sodium salt of phenol-tetrabromo-phthalein, is unfortunately more toxic than is desirable.

Many, but not all, patients complain of nausea; some are disagreeably ill; rarely one is alarmingly ill. The severe reaction is distinctly one of vasomotor shock. When once produced it convinces one that careful selection of cases is essential and hospitalization for all is advisable.

No one should undertake the procedure unless

the patient has been given a thorough physical examination by a competent internist. By all means a renal and liver function test should be included, as these are the excretory organs for the dye. Patients with cardio-vascular, renal, or hepatic disease, and the neurosthenic should be refused.

However, no fatalities have been reported. Ottenberg and Abramson<sup>5</sup> report no appreciable damage to vital organs in animals, following the use of the average dose (0.1 gram. per kilogram.) The reaction can be partially avoided by very slow injection of the solution and severe symptoms are relieved by adrenalin.

Thus, being able as we now are, to make rather frequent radiograms of the gall-bladder, we have been able to demonstrate, for the first time, something of the physiology of that organ in the intact human subject.

Whatever its entire function may be, the normal gall-bladder does at least receive, store, concentrate, and eject bile. If a standard technique is followed, such as that advised by Graham, these functions can be visualized by a series of films.

According to Graham, Cole, and Copher,<sup>6</sup> "a normal gall-bladder will begin to cast a shadow from three and one-half to five hours after the injection; will show a tendency to change in size; will cast its heaviest shadow between sixteen and twenty-four hours, and empty in about forty-eight hours. The shadow shown on the four- or eight-hour plate is almost invariably larger than the subsequent shadows."

Stewart<sup>7</sup> finds the normal gall-bladder smaller, but more distinct, at seven or eight hours. Carman and Counseller<sup>8</sup> find the normal the largest at eight hours, but most dense at twenty-four hours. The one patient of our series proved at operation to have no apparent disease, showed the largest shadow at five hours, the smallest and least distinct at twenty-four hours.

When the series of films fail to show the filled gall-bladder, when size, shape, or character of

<sup>2</sup>Leonard, R. D.: *Amer. Journal of Roentgenology*, 10:521, July, 1923.

<sup>3</sup>Discussion: *Radiology*, 2:232, April, 1924.

<sup>4</sup>Graham, E. A., and Cole, W. H.: *Roentgenologic Examination of the Gall-bladder*. J. A. M. A., 82:613, February 23, 1924.

<sup>5</sup>Ottenberg, R., and Abramson, H. A.: *Production of Liver Necrosis*. J. A. M. A., 84:800, March 14, 1925.

<sup>6</sup>Graham, E. A., Cole, W. H., and Copher, G. H.: *Visualization of the Gall-bladder by the Sodium Salt of Tetrabromophenolphthalein*. J. A. M. A., 82:1777, May 31, 1924.

<sup>7</sup>Stewart, W. H.: *American Journal of Roentgenology and Radium Therapy*, 13:259, March, 1925.

<sup>8</sup>Carman, R. D., and Counseller, V. S.: *Roentgenologic Diagnosis of Cholecystic Disease with the Aid of the Sodium Salt of Tetrabromophenolphthalein*. *The American Journal of Roentgenology*, 12:403, November, 1924.

filling are grossly abnormal, disease is usually present. When size and density do not vary as in the normal, it is assumed that the function of the gall-bladder is impaired by disease.

Our experience with eleven patients is, of course, too limited to permit of definite conclusions. Those who have had opportunity to follow the greatest number of patients to operation report very favorably on the diagnostic accuracy of the test.

In addition the shadow sometimes serves to localize questionable stones, and occasionally helps to show stones which have not cast a shadow on preliminary films.

The test is quite new but already of great value. However, a word of caution seems in order against too implicit reliance upon its diagnostic value for, as yet, a sufficient number have not been rigidly proven to establish the limits of normal variations or the significance of slight departure from normal. The ultimate evaluation of the method must come only from operatively proven cases, and not by comparison with clinical data or the pathologist's report of *slight* chronic inflammatory change.

Future investigations will undoubtedly establish the value of this method.

Mullikin and Whitaker<sup>9</sup> quite recently report much less toxic reaction from the use of a purified sodium tetraiodophenolphthalein. Other investigators (Menees and Robinson;<sup>10</sup> Steward, Wm. H.)<sup>11</sup> have very recently reported successful visualization of the gall-bladder, with little or no toxic reaction, following the oral and intrajejunal administration of both the brom and iodo compounds.

It is to be hoped that an even less toxic drug will be produced, and that renal and hepatic function tests can be combined with this one. Much light should be shed on other questions, such as the fluoroscopic localization of tenderness, adhesions, and duodenal deformity. Already the method, in the hands of Silverman and Men-

ville,<sup>12</sup> appears to confirm the assertion of Meltzer upon which the work of Lyon is based.

#### CONCLUSIONS

The X-rays, as an aid in the diagnosis of gall-bladder disease, have been of considerable value in the past, but have left much to be desired. The newer method of visualizing the gall-bladder, is at present in an early stage of development. However, it bids fair to assume the same importance in gall-bladder diagnosis as the use of other opaque media are in relation to the gastro-intestinal and urinary tracts.

#### CLINICAL AND LABORATORY DIAGNOSIS OF DISEASE OF THE GALL-BLADDER.

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With all our diagnostic methods no one questions the value of a painstaking history in the diagnosis of disease. The relative value of histories taken with equal care will vary, according to the character of the disease, the ability of the laboratory or X-ray to make an exact diagnosis, and the seriousness of the complaint. The history is of utmost importance in any complaint referable to the gastro-intestinal tract. It is with the symptoms referable to the gall-bladder or ducts that the history reaches its greatest value. In the more evident cases nothing is needed but a carefully taken and intelligently given history to make a positive diagnosis. However, these cases are few and it is with the unusual and the complicated ones that the history is often the deciding factor in making the diagnosis which on operation proves correct.

The most commonly confusing conditions are those which produce symptoms caused by inorganic stomach diseases. The next in order named are, organic stomach lesion, diseases of the appendix, liver, right kidney and pancreas. The X-ray will aid in ruling out the organic and inorganic lesions of the stomach. The physical examination, history, and laboratory, will rule out the appendix. The liver is so often mildly involved that it cannot always be ruled out or correctly included in the diagnosis. The right kidney is eliminated by the laboratory, X-ray and cystoscopic examination and the pancreas by the blood sugar.

<sup>9</sup>Mullikin, G., and Whitaker, L. R.: The Clinical Use of Tetraiodophenolphthalein in Cholecystography. *Surg. Gyn. and Obstetrics*, 40:646, May, 1925.

<sup>10</sup>Menees, T. O., and Robinson, H. C.: Oral Administration of Sodium Tetrabromphenolphthalein—Preliminary Report. *The American Journal of Roentgenology*, 13:368, April, 1925.

<sup>11</sup>Steward, Wm. H.: Correspondence. *The American Journal of Roentgenology*, 13:378, April, 1925.

<sup>12</sup>Silverman, P. N., and Menville, L. J.: Observations of the Visualized Gall-bladder by Graham Method. *J. A. M. A.*, 84:416, February 7, 1925.



One must get from the patient a clear knowledge of the complaint, whether it is actual pain or merely discomfort. The character of the pain must be noted; a dull constant ache, a pain that causes nausea, a pain that "doubles one up," or merely a feeling of discomfort that attracts attention only when the mind is not occupied. Is the pain always definitely localized or is it referred? Note carefully the point to which it is referred. Most pains referred to the right shoulder are caused from gall-bladder pathology. Is there, or was there fever? Did the fever precede the pain? Did the pain come before or after eating? did the pain follow a medical gall-bladder drainage? A patient often knows from experience those foods which cause distress. These are strikingly similar to those advised against in chronic diseases of the gall-bladder. The information concerning the regularity of the meals, should be elicited with great care. Next, the regularity of the bowels, if they were regular without cathartics (patients often say they are regular but on more careful questioning, it is because they take a laxative almost daily to accomplish this) or if there were alternate spells of diarrhea and constipation. The patient should be quizzed as to the character, color and size of stool; the time required for food to pass through the alimentary tract. If a history of diarrhea is obtained, the question of colitis should be considered. Has the patient noted mucus in the stools; or has there been lower abdominal pain, or tenderness. Gas on the stomach or abdomen, so described, is such an exceedingly common symptom in a number of conditions, that it is often overlooked. A history of this, definitely established, is of sufficient importance to necessitate a thorough investigation in the gall tracts.

Jaundice is a symptom that may be of great value or it may be most misleading. As a single symptom, too much importance should not be placed on it.

The physical examination, as in any diagnostic procedure, should first be general and without too much regard for the history obtained. The first special points to be noted are the skin and conjunctivæ. The liver should be carefully precussed out as to its upper border and palpated for the lower border, so that the size can be noted. After this, examine carefully for any points of tenderness in the region of the gall-bladder or upper abdomen. Often, the findings at the time of physical examination are entirely negative.

After giving due credit for and placing the proper value on a carefully taken history, the fact still remains that we are constantly striving for absolute accuracy in diagnosis. It is probable that the time will come when all diseases are diagnosed with the same accuracy as we now diagnose syphilis, malaria, typhoid and others. In any disease where no such method of accuracy prevails without exploratory operation, any aid of proved value is a most welcome assistance. Even at the exploratory the surgeon is often at a loss to say as to the importance or necessity of removal or to determine the pathology without microscopic sections. Hence the extensive laboratory investigation and the constant effort on the part of the roentgenologist to improve his technique in gall-bladder pathology.

The laboratory is making an effort to assist in establishing a positive pre-operative diagnosis, and to increase the value of a prognosis, either from medical or surgical handling of gall tract pathology.

Routine blood examinations should be done; but in the chronic cases (and it is this type where the skill in diagnosis is taxed) it reveals but little change in the picture. The leukocyte count also rarely shows an increase over the normal except in those mild flare-ups of old chronic cases.

It is the option of the writer that gall-bladder drainage by the Meltzer-Lyon method is of considerable value in the diagnosis of gall-bladder disease. If this procedure is to be of value, however, the individual making the observations must carry out the technique with exacting care and completeness; and must have observed a large number of cases both normal and abnormal. The laxity with which the technique has been carried out and lack of careful observation is responsible for a great deal of the criticism of the method. In addition to the usual repeated microscopical examination a careful microscopical examination of both the duodenal contents and the so-called gall-bladder bile should be made.

The gastric analysis in our experience has proven of no diagnostic value. It is done as a routine because of its prognostic value. We have found that those cases showing normal or high acidity have a favorable prognosis particularly after operation. Those cases showing a total absence of free hcl. and a low total acidity are very slow in their recovery and the final results are as a rule unsatisfactory. This is also true of those cases handled medically.



The liver function test so far has not been an aid in making a diagnosis of gall-bladder pathology. It is of most importance in determining the condition of the liver. It also answers these questions for the surgeon: (a) Can the patient undergo the operation? (b) To what extent can the operation be safely carried? It should be done routinely.

The Icterus index test was developed by Dr. Alice R. Bernheim<sup>1</sup> of New York Hospital, whose technique we follow.

In our series of cases it has proven positive at operation in all except two cases and these two were more a peri-Cholecystitis rather than a real cholecystitis. In the cases which have not gone to operation the result of the icterus index test has paralleled the other findings. We consider this test of great importance in making a diagnosis. Where the icterus index is normal the other symptoms should be very pronounced before operation is recommended.

#### CONCLUSIONS.

1. At present we have no method whereby we can invariably make a positive diagnosis of gall-bladder disease.
2. It is essential that our diagnostic study of the patient include every clinical and laboratory aid.
3. The most important aids in the writer's experience are: (a) the history, (b) X-ray examination, (c) medical gall-bladder drainage, (d) icterus index test, (e) physical examination.

### POST-OPERATIVE CARE OF GALL-BLADDER DISEASES

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Post-operative care of gall-bladder diseases is a matter of no little importance. This care has much to do with the comfort of the patient, the rapidity of recovery, and extent of recovery. It frequently results in recovery when otherwise the case would prove fatal.

Many surgeons are especially ready to operate, and from this get a thrill, but woefully neglect the post-operative care. It behooves a surgeon to give post-operative care as well as to diagnose the case, use surgical judgment in advising or withholding an operation, or in operating.

While in this short paper I will call to your attention some of the most common conditions with which we have to deal, there is much of vital importance that might be written.

The points of special importance will be presented under the following:

1. Position.
2. Shock.
3. Gastro-intestinal tract.
4. Incision.
5. Convalescence.

The position most frequently advised and most restful to patient is the horizontal one on back, but this varies with opinions of various surgeons and in certain conditions of patients. If congestion of lungs is feared, breathing is poor, or cardiac weakness exists the Fowler position is desired, or frequent changing from side to side is advised to prevent hypostatic congestion of lungs. Condition of marked shock calls for elevation of foot of bed.

The position should also be considered as regards drainage and if possible the horizontal position maintained for five to eight hours for isolation of discharge to gall-bladder region as far as possible.

#### SHOCK

Shock is characterized by a vaso-motor disturbance, and results in an increase in pulse rate with decrease in tone and volume. The blood pressure falls, respiration becomes more rapid and shallow, pupils dilate, and patient becomes pale, with cold extremities and probably a cold, clammy sweat. The extent of shock varies but is usually present after every operation to a certain extent.

Shock is greater in proportion to trauma, the length of operation and anesthesia and with the extent of the hemorrhage.

The treatment for shock is either active or preventive.

Every effort should be made to prevent or lessen shock which is done:

1. By building up patient if possible when needed with food, rest, and tonics.
2. By reducing trauma, length of operation, and hemorrhage to a minimum.
3. By the use of morphine and atropine half hour before operation.
4. By supplying abundance of fluids to the system by hypodermoclysis or proctoclysis.
5. By digitalizing a myocardially insufficient heart before operation.

<sup>1</sup>Journal A. M. A., January 26, 1924, vol. 82, pp. 291-295.

6. By having warm operating room and bed on returning to his room.

The active treatment calls for a trained nurse who is able to recognize early symptoms of shock, who is to institute treatment promptly, or call for assistance. Active treatment varies with the degree of shock. When severe and sudden in onset the use of one to one-thousand adrenalin solution, minimum ten, hypodermically, and the elevation of foot of bed are of first importance.

Normal salt solution hypodermically, or intravenously if urgently needed, is given.

As the effects of adrenalin are very transitory it is used very satisfactorily in the normal salt solution as hypodermoclysis.

Blood transfusion is indicated where patient is very anemic.

Somewhat the same results, but in a lesser degree, are gotten by bandaging extremities tightly with elastic bandages from tips of toes and fingers to the body.

The most useful drugs besides morphine, atropine, and adrenalin, already mentioned, are:

1. Camphorated oil.
2. Caffeine and sodium benzoate.
3. Digitalis.
4. Strychnine.

These are used symptomatically.

Care of gastro-intestinal conditions.

These are almost constantly present in post-operative gall-bladder diseases: nausea, thirst, loss of appetite, constipation, "gas pains" and gas distention are especially troublesome. These symptoms vary greatly in severity, but at times become quite alarming.

The most effective treatment for the nausea and vomiting is the gastric lavage of bicarbonate of soda solution (one tablespoonful to half-gallon of water.) The best time to use it is immediately following the anesthetic while the patient is still on the operating table.

Liquids are permitted when patient has reacted from anesthetic. Hot water is best borne as a rule, but cold or carbonated are more satisfactory at times.

After the first twenty-four hours and nausea is over, liquid nourishments are added and continued until bowels have moved well from purgative given on the third post-operative morning.

Constipation, "gas pains," and gaseous distention are usually done away with when purgative has become effectual. Passing of rectal tube, or the giving of an enema will give considerable relief usually.

The diet is increased in quantity as well as quality as patient shows ability to take care of it.

*Incision.*—Post-operative attention to gall-bladder incision is indicated for the discharge, for infection, for stitch abscesses, and for the removal of sutures.

A close watch should be kept on the tube to insure full drainage. The dressings should be changed whenever soiled. If cigarette drains are used one should be removed the following morning to allow free drainage. Whenever dressings are changed the incision should be inspected for infection, or stitch abscess and an early opening up between sutures and placing of rubber tissue, or the removal of a stitch will tend to prevent extension of infection, and possibly prevent a ventral hernia, eventually.

If temperature should continue or rise after the third day an inspection of the incision and stitches for infection should be made and taken care of as advised above. The removal of stitches should take place the eighth to tenth day. It is useless to state that at every redressing utmost care is taken to avoid infection.

#### CONVALESCENCE

Convalescence from gall-bladder operations should be a gradual but a progressive return to health and strength.

Patients are given permission to put forth but very little additional effort from day to day and advised at all times to limit efforts short of fatigue and rapid pulse.

Patient's surroundings whether in hospital or home should be congenial and free of cares and worries. Patient should have wholesome food and abundance of fresh air, sunlight, and rest. Tonics and laxatives are given when indicated.

In presenting this paper I have brought you nothing new. I simply hope to call to your attention the importance of post-operative care of gall-bladder condition and remind you of a few of the most common conditions that give us concern.

I also desire to make it especially impressive that this post-operative care is no less a surgeon's responsibility than the operation itself.

#### DISCUSSION

OF THE PAPERS OF DRs. BEALS, CASON AND LYELL  
*Dr. W. McL. Shaw, Jacksonville:*

I will confine my remarks more to the indirect evidence of gall-bladder disease.

This method which Dr. Beals has outlined

promises a great deal to the X-ray man. However it is just in its infancy. We feel that it is a measure to be resorted to only when all other methods have been exhausted in the diagnosis of gall-bladder disease. It is certainly a hospital measure, you can not do it yet in the office because you do get reactions. I think we will all be impressed with the reactions. In our work with the gall-bladder we have followed the technique of Leonard and George of Boston who brought out this method of indirect signs. We still think if you look hard enough and long enough, you will find some evidence of gall-bladder disease if it is there.

(X-ray slides shown).

If we can visualize the kidney or gall-bladder by injecting dye we have gone a long way. For instance, if the gall-bladder did not have a stone in it and you were looking for it, you would have to have many films all over the right side to get the gall-bladder, but if you can inject dye and get the gall-bladder immediately, you have gone a long way toward localizing it.

(X-ray slides to demonstrate indirect evidence of gall-bladder disease).

*Dr. Simmons, Miami:*

I don't think that I can add anything to what has been said on this paper as I feel that the post-operative care of a great many surgical conditions is overdone rather than underdone. You take the average laparotomy, as a rule if you leave the patient quiet, not fed them too early, give them morphin in small doses repeated as often as necessary to keep down the pain and keep them reasonably quiet, it is about all that is necessary in the majority of cases. Of course, in gall-bladder cases where you have a drain, perhaps there is some difference in your after-treatment. I think one of the main things in gall-bladder drainage is to leave your drain in sufficiently long to get rid of your infection, but just as soon as you feel your infection has subsided sufficiently, at that time I think your drainage should be discontinued as rapidly as possible, and have the wound healed as soon as it is possible to make it. I think a great many times in draining the gall-bladder the drainage tube is left in too long. Of course, we know in simple gall-bladder, say for stone, if you drain a gall-bladder for simple stone, as a rule there is not a great deal of infection, and what infection there is will clear up in a few days. In these cases the

quicker you get the drain out, and the wound healed, the better.

About your post-operative nausea: I think that is the thing that worries a great many of us, and sometimes I believe that a great deal of this post-operative nausea is due to the after-care of the patient. My experience and my policy has been for the last ten or twelve years, not to give my patients anything for the first, say, five or six hours afterward, then begin giving small quantities of tap water, or as the Doctor says in his paper, possibly warm water. I think that routinely this is better than cold water. Give it in small amounts frequently repeated. If the patient vomits the first few times, then give them large quantities of warm water and let them wash the stomach out. But if that does not relieve, then of course give a lavage.

About the morphin: I think a great many of us are prone to withhold morphin from post-operative cases. Of course, we must use judgment, but I think the patient is much better off with small repeated doses of morphin to keep the patient as quiet and comfortable as possible, for say twenty-four to seventy-two hours. If we withhold the morphin they have to spend restless nights. I think that the nausea is also relieved by giving morphin in small repeated doses.

*Dr. Cason, Jacksonville (concluding):*

If you will be sure to do a kidney functional on your patient before injecting the dye, and then give the dye very slowly, you will have much less toxic symptoms. It has been our experience and observation that no patient should have the dye given intravenously until a kidney functional has been done, so that if your heart is not all right and your kidney function is not all right, you had better leave your dye out regardless of the condition you may suspect or how anxious you may be to make the correct diagnosis.

## PRACTICAL MANAGEMENT OF THE HYPERTENSION SYNDROME\*

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Perhaps no subject in modern medicine has had a greater appeal to the popular imagination than blood pressure. Indeed, "speaking of blood pressure" has become a more general topic of discussion than that well-known phrase, "speak-

\*Read before the Second District Medical Society, Quincy, July 15, 1925.



ing of operations." Many a patient has caused his physician to doubt the boon of the sphygmomanometer. Still, in the main, the public has been correct in its insistence on the importance of blood pressure, since it has been estimated that more than 5,000,000 people in the United States are now suffering from hypertension, with a yearly mortality exceeding 100,000.

In a recent study of 3,000 consecutive admissions to the Emory Division of the Grady (City) Hospital in Atlanta, caring exclusively for negroes, we found 600 cases of cardiac disease. Sixty-four per cent of these were males and thirty-six per cent were females. The average systolic pressure of this entire group was 172 mm., supporting the fact that the usual patient suffering from cardiac disease has hypertension. Seventy-two per cent of these cases occurred between the ages of 30 and 50, the average age being 41.

When we realize that diseases of the heart and vascular system now lead all causes of death, particularly those during man's most productive period, and that cardiac disease, cerebral hemorrhage and chronic nephritis are the most frequent terminations of hypertension, we grasp the importance of this subject.

In this discussion we refer to hypertension as more or less of an entity though it is frequently the result of well-defined organic disease. Many times it is discovered accidentally in a routine examination, with or without other demonstrable pathology. The hypertension syndrome is used to include all cases of high blood pressure regardless of etiology.

#### ETIOLOGICAL FACTORS

There is no affection of the human race which has had a greater number or wider variety of attributed causes. Heredity, overwork, worry, high protein and high salt diets, alcohol, tobacco, tea, coffee, infectious diseases, syphilis, focal infection, constipation, overweight, hypersecretion of the suprarenals, disturbances in other glands of internal secretion—these are only a few of the things which have been mentioned as causes of hypertension.

In our study of the 600 cases of cardiac disease in negroes, basing our findings on the clinical examination, blood and urine chemistry and autopsy findings, we divided them into the following groups: Syphilitic 52 per cent, arteriosclerotic 21 per cent, nephritic 12 per cent, rheumatic 7 per cent, and doubtful 8 per cent. The

high incidence of syphilis in the negro accounts for the relatively low age period. The most frequent antecedent diseases which might have had some influence on the condition were: Frequent colds 67 per cent, gonorrhea 56 per cent, influenza 24 per cent, tonsillitis 23 per cent, pyorrhea 18 per cent and rheumatism 17 per cent. It is interesting to note that there were only two cases of polyarthritis, one of chorea and one of goiter in the entire series. Although these diseases might be considered merely as being associated with hypertension they no doubt played an important role in its termination.

The most recent work has been done by Major<sup>2</sup> and his co-workers at the University of Kansas School of Medicine. In studying the effect of protein metabolites on the blood pressure of dogs they found that methyl guanidine given intravenously in doses ranging from .1 gm. to .2 gm. per kilo of body weight would cause the blood pressure to rise from 120 mm. to 240 mm. for a period of from four to five hours. Methyl guanidine is excreted in normal urine and is a product of protein metabolism closely related chemically to creatine and creatinine. In a few clinical cases of hypertension methyl guanidine has been found increased in the blood and decreased in the urine. These findings are at least suggestive and may lead to a clearer understanding of the entire subject.

#### CLASSIFICATION, DIAGNOSIS AND PROGNOSIS

Many classifications have been suggested—a result of the uncertain etiology. A practical division is that suggested by Warfield<sup>3</sup> of (1) subacute and (2) chronic hypertension. Under subacute is included the hypertension of acute nephritis, toxemias of pregnancy and other limited disturbances. He divides chronic hypertension into three subgroups: (1) Hypertension associated with chronic nephritis in which the pressure usually ranges between 120 to 140 mm. diastolic and over 200 systolic. Signs of kidney disease, such as fixation of specific gravity, albumen and casts in the urine, decreased 'phthalein output and retention of nitrogenous products in the blood are always present in this group. (2) Hypertension associated with arteriosclerosis. The earliest signs of sclerosis are usually found in the retinal vessels. (3) Hypertension in which there is no demonstrable gross pathological change—so-called "essential hypertension." The latter has often been referred to as "benign hyper-

tension," but increasing evidence leads us to believe that no hypertension is really benign. Recent studies<sup>4</sup> have shown sclerosis of the arterioles in the kidneys in all cases of essential hypertension. Sclerosis of the arterioles of other organs as the spleen, liver and pancreas are not infrequently found. Warfield<sup>3</sup> admits an increase in connective tissue around the arterioles in the kidneys of patients suffering from essential hypertension.

The proper classification depends upon a careful systematic study of each individual case. If heredity is the single greatest factor in longevity<sup>5</sup> it is certainly a considerable factor in those diseases affecting longevity, hence, a comprehensive family history, as well as a personal history, aids us in understanding a patient. That brilliant results may often be obtained in patients with bad heredity is shown by a recent case<sup>6</sup> report of ours on diabetes mellitus associated with "familial hypertension." A complete physical examination together with such laboratory and X-ray studies as will help disclose foci of infection and associated diseases is necessary. Overweight, lack of exercise, overwork, overworry, pyorrhea, abscessed teeth, diseased tonsils, chronic sinus infection, chronic appendicitis, chronic cholecystitis and chronic prostatitis may be merely conditions associated with and not the cause of the hypertension. These should be discovered and corrected but it is a mistake to mislead a patient into the belief that they are the cause of his disease and that their removal will effect a cure. It is much better to use the term "arrest" in discussing hypertension than the term "cure." The patient with hypertension should be carefully watched throughout the remainder of his life.

Having discovered hypertension and searched for associated diseases we are next concerned as to the amount of pathology present. The early case shows variations in blood pressure at different periods of the day, and in occasional cases after rest in bed from one to several days the pressure is found remarkably lowered. A comparison of the amount of night and day urine is helpful, the patient having a larger output at night than during the day, has already developed kidney impairment. If the specific gravity of each separate specimen voided during the 24 hours remains at or near the same level we have "fixation of specific gravity," a positive indication of chronic nephritis. Hyaline casts with or without a trace of albumen are early find-

ings. The 'phthalein output may be normal or even increased in the early case. Blood chemistry is helpful not only in diagnosis, but particularly in the prognosis of advanced cases. Increase of the non-protein and urea nitrogen, uric acid, creatinine and blood sugar, one or all, are frequently found especially in the overweight, toxic individual. Retention of chlorides has not been a frequent finding in our cases. Non-protein and urea nitrogen being largely exogenous in origin are influenced to a considerable extent by the diet, this being also true of the blood sugar. Creatinine, however, being endogenous in origin gives us a clearer insight into the stage of the disease. We believe like Myers that an increase in creatinine above 1.5 mgm. per 100 cc. indicates nephritis and a constant increase above 5 mgm. per 100 cc. is prognostic of a fatal termination within two years. This is not true in acute nephritis since we now have under observation one patient who showed 19 mgm. per 100 cc. during an acute attack of Bright's disease and who has remained entirely well for three years.

#### TREATMENT, GENERAL AND SPECIFIC

Remarkable results have been obtained in the prevention of infectious and contagious diseases. Equally remarkable results may be obtained in the prevention of hypertension and its associated diseases. In fact, herein lies our most important point of attack, for although the average span of life has been increased, due to the reduction of infant mortality and the prevention and cure of infectious diseases, statistics<sup>7</sup> show that there is an increasing mortality rate above the age of 45. Periodic health examinations of the apparently well, sponsored by the American Medical Association, have their greatest field of usefulness at this period of life. A careful examination followed by sound advice in reference to diet, habits of living and general hygiene will prevent or at least delay the approach of degenerative diseases.

In our experience we have been particularly impressed by the accumulated effects of infection. The infections of childhood usually accompanied by nephritis, often overlooked or passed over lightly, no doubt have a definite place in the causation of later hypertension. It is encouraging to note that pediatricians are beginning to study the subject from this standpoint. If we search deeply enough into the histories of our patients who state they have never been sick in bed a day in their lives we will often find that



they have had frequent colds, sore throat, tonsillitis or sinus infections, which were ignored at the time but which exacted their toll later on in life.

In an analysis<sup>8</sup> of the physical defects and influential living habits of 13,308 white men with normal blood pressure as compared with a similar group of 1,021 having a blood pressure of from 20 to 40 mm. above normal, the only factor showing sufficient variation to be of striking importance was overweight. In those which showed twenty per cent or more overweight, hypertension was twice as frequent. Therefore, it seems logical to reduce the overweight patient suffering from hypertension. There should be a reduction not only in protein intake but also in carbohydrates and fats giving just sufficient to meet the patient's caloric requirements for the maintenance of his ideal weight. A correct quantitative diet is even more important than a qualitative one.

Stasis and putrefaction in the large intestine, especially cecal stasis, must be overcome. A chronic appendicitis, with adhesions either congenital or acquired inhibiting the motility of the cecum and ascending colon is a not infrequent cause of hypertension, as we have often seen proved by the removal of the appendix and the freeing of the adhesions. Acidophilus milk and lactic acid milk with or without lactose have proved helpful to us in overcoming intestinal stasis and toxemia. We recently reported the case<sup>9</sup> of a physician, aged 47, who was relieved by a reduction in diet and the taking of lactic acid milk with lactose. The lactic acid increasing the digestibility of the milk and the lactose decreasing the number of colon bacilli and increasing the number of acidophilus bacilli in the intestinal contents. Starvation may be resorted to in extreme cases. A recent patient, female, aged 42, weighing 210 pounds, having a systolic pressure of 215 mm. and diastolic of 120, had a complete left hemiplegia. Starvation reduced her weight 37 pounds in six weeks with a corresponding reduction in blood pressure to 150/90 with a clearing of the hemiplegia to such an extent that she could walk unassisted and use her left hand at the end of eight weeks. At first the starvation was complete, later she was allowed a small quantity of five and ten per cent vegetables and fruit juices. High colonic irrigations, we believe, assisted in her recovery. For the over-

worked and worried, one rest day each week, together with one fast day, is helpful.

The hypertension of women at or near the menopause has proved exceedingly difficult to manage. In our experience little benefit has been derived from the glands of internal secretion given in any manner whatsoever. However, general experience has shown that women tolerate hypertension better than do men, and occasionally the high pressure comes down without any treatment after the menopause is passed.

The young individual with an exceedingly high pressure is a very bad risk and drastic measures are entirely justifiable with these patients. Decapsulation of one or both kidneys should be done as a life-saving procedure. The nitrites, veratrum viride and bleeding are also emergency measures. Of these we have used bleeding most frequently. Repeated bleedings have been considered by some to exert a favorable influence on the progress of the disease. This may be indicated in those plethoric individuals having a high hemoglobin and red cell count.

Allen<sup>10</sup> has repeatedly called the attention of the profession to the beneficial effects which his patients have received from a low salt diet. His results have not been generally confirmed.<sup>11</sup> Personally, we have not been able to secure a close enough observation on a sufficient number of patients to express an opinion as to its merits, although we know it decreases the appetite and in consequence the food intake is lessened.

Major, previously referred to, has made some interesting observations on the hypertension produced by the guanidine bases. For instance, amyl nitrite and veratrum viride are very transient and evanescent in their effects. Equal parts of calcium and potassium chloride produce more marked and prolonged decrease in pressure, furthermore, if these are injected simultaneously with the guanidine no increase in pressure results. Extracts of various tissues were tried. Liver extract reduced the pressure and kept it so. He stated that if liver extract is to be used in the treatment of hypertension its effect on the guanidine high pressure may furnish a means of estimating the dosage. Apparently much may be expected from these researches, since the problem has been attacked from a new angle.

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### SOME REASONS WHY WE SHOULD AFFILIATE WITH OUR COUNTY AND STATE MEDICAL ASSOCIATIONS\*

J. C. DAVIS, JR., M.D.,  
Quincy, Florida.

When two or more medical men are gathered together and converse on a medical subject a medical society is then in progress. An eminent physician once said that he was always able to obtain a valuable point or idea from any physician with whom he might converse thirty minutes, regardless of how weak the man was, unless he was a moron or mediocre. Nothing in medicine or any other great undertaking can be accomplished without concerted action. The combining of units is the point to be stressed. The more dollars, the stronger the bank. The more brick, the stronger the building. The more physicians, the stronger our association and the stronger the individual physician as a unit will become because of his affiliation. I have during the past 16 years attended a number of medical meetings, including A. M. A., S. M. A., F. S. M. A., County, etc. I have always derived invaluable information from each meeting and nearly always something from each paper, if nothing more than a minor point. I always get an idea from each medical journal that comes to my desk. Oftentimes one article will contribute a thought worth the price of the whole year's subscription, and probably an idea that enables me to save a life. I have yet to feel that I was not more than repaid in time and expense for each trip to a medical meeting. I know that my

patients and bank account have equally been benefited. Intermingling with your fellow practitioner and getting acquainted, so to speak, is invaluable and broadens our vision. Aside from this, our clientele is entitled to the best that is in us and we are not fair to them unless we take advantage of every opportunity whereby we are enabled to give a greater service to the unfortunate sick.

Therefore, our service to humanity is the coordination of medical knowledge and skill in such a way that the sick individual receives the benefits of the most complete diagnosis and the most efficient therapeutic measures possible.

The elimination of discord, creating good fellowship, and stimulating friendly rivalry based upon the character of the work rather than upon individual triumph. The discord in the profession is practically always due to petty jealousies. These are often temperamental and seemingly insurmountable, yet they can be overcome by getting acquainted with one's colleague and considering him a colleague rather than an opponent, unless you have a hair-brained man to contend with and in the profession you will find them very rare. Physicians represent the best of their communities, and when you find a physician stabbing his fellow practitioners in the back and trying to tear him down in place of lending a helping hand, you see a man lowering himself in the minds of intelligent laymen and bringing a stigma on a noble profession. Personally, I have never permitted myself to be an enemy to any man, in or out of organized medicine. I have always felt that being an enemy to a physician or refusing to assist, meet in consultation, or refusing to consider suggestions from your fellow practitioner would justly entitle that type of a man to be classed as an "egotistical hairbrained hyphenated American" in the language of Theodore Roosevelt. Digressing at this time, and suffice it to say, "ethics" is not supposed to be my theme, but the society being the remedy for such ills, is responsible for my digression. One of the chief objects of this meeting, I am sure, is to bring you men in touch with one another. The personal contact, exchange of views, to learn what others are doing, and in that way to familiarize yourself with the work of the whole district—that to my mind is exceedingly valuable. Cooperation and organized effort succeed just insofar as they measure up to the principles that inspire and govern their existence. It is these

\*Councilor's address to the Second District Medical Society of Florida. Meeting held at Tallahassee April 15, 1925.

principles that determine prestige and accomplishments. Accordingly as these principles are comprehensive, the purposes and achievements of an association will be narrow and limited or broad and inclusive. Let's summarize from Warnshuis' "Four Reasons for a Medical Society":

1. Acquaintance, to bring about good understanding.
2. Fellowship, to establish good will.
3. Friendship, to encourage brotherhood.
4. Education, to increase individual efficiency, clientele reaping.

We hear a great deal about pessimism in medicine, and all of us have a hard time. **That is a part of life.** We must anticipate the bitters and the sweets, as all can't be wine and cake. But no one can attend these medical meetings throughout the country and fail to come back more optimistic. We owe it to the profession to belong to our medical societies. We should be in or out of the profession. Be a regular doctor or a regular quack. Fall in line and be affiliated with your association for the advancement of the cause. The various cults are mobilizing their forces into one group. You see they appreciate being organized. We can only hold our own by getting together. How often have I heard it said, "How can we put faith in a medical group that represent the same school and yet are divided—none of them get along"? They cuss what the other fellow does when he is doing what his school and the best men in his profession believe in. Gentlemen, it is time we were cooperating, and it should be true that every physician is the other's friend, and then, and not until then, can we expect to receive the support and respect from our fellow man and recognition that our profession merits. Otherwise we are a disgrace to a noble profession. Don't try to dictate to your patient whom he must have. Don't forget your patient has a right, and it should be respected.

Your patient is entitled to the knowledge and skill of any licensed physician he fancies to choose, and the honest physician who has his patient's interest at heart will see that his patient's wishes are duly respected and not force consultants and attendants contrary to their wishes. Now, gentlemen, a little further digression is necessary at this time in order that you may fully realize the greater importance of why you should be a member of our association. Florida, as you know, is the playground of America. It is rapidly attracting the eyes of the world, for health and for pleasure. We have 1,600 physicians in the state, which is the normal ratio between physicians and laymen. Yet last year 2,000 requests for reciprocity were made to the secretary of our Board of Examiners. Outside physicians and the irregulars have organized for the purpose of having our Legislature amend our present Medical Practice Act so as to make it mandatory that the Medical Examining Board issue license by reciprocity. Should this pass the Legislature and become a law, this state will become the greatest center for medical imposters and quackery the world has ever known. Now if we as a unit before we leave here, have every physician in the Second District go on record as opposing any such legislation it will do good. Our Senator voluntarily came to me the other day and wanted to know what we wanted him to do at Tallahassee, and he assured me he was with us and would stand by the medical profession.

I have taken advantage of this opportunity and consider this my official visit and message to the members of each county in the Second District. I urge the appointing of workers to get eligible members into the association and report at another meeting and that we all work in harmony to the end that we may elevate ourselves and profession.



# Looking Backward Over Fifty Years of Health Work in Florida

JOSEPH Y. PORTER, M.D.,

*Former State Health Officer of Florida,*

1889 - 1917

*Serial No. 3.*

As a most fitting ending to a history of a time full of pathos and tender recollections and associations, the following taken from the *Times-Union* of January 22, 1889, very graphically gives a pen picture of happenings above mentioned and the comment of the Editor:

(From the Florida Times-Union, Tuesday, January 22, 1889)

## DOCTOR PORTER'S SURPRISE

"A Watch Set on Him" by the Citizens Auxiliary Association—High Honors to the Surgeon in Charge—A Series of Resolutions in His Praise, and a Beautiful Gift as a Souvenir of His Mission Among Us.

A special meeting of the Jacksonville Auxiliary Sanitary Association was held at the rooms of the Board of Trade yesterday morning at 10:30 standard time, pursuant to a published notice. President P. McQuaid presided, and there were present many members of the Association, representatives of the Board of Health, City Council, and numerous citizens. The purpose for which the meeting had been called was not indicated in the call, and an unusual degree of interest and curiosity was therefore manifest on the part of the public. Long before the appointed hour nearly every seat in the committee room of the Board of Trade was occupied, and when finally the meeting was called to order dozens of leading citizens were standing in the rear of the apartment. The scene presented somewhat the appearance of old epidemic days, for all the war-horses of the siege of Jacksonville were there. President McQuaid presided; on his left was the old-time secretary, Mr. Adams, who never lost a day from his duties until the raising of the siege; near him sat Dr. John C. L'Engle, the indefatigable chairman of the Committee on Sanitation, which gave employment to an army of men and turned charity into utility in the disbursing of the people's generous contributions; Peter Jones, his coadjutor, was not far off, and near him sat President Neal Mitchell of the Board of Health and Dr. R. P. Daniel of the same body. Over in the dark, northeast corner were two other executive committeemen, Messrs. McMurray and Schumacher, whose innate modesty always forces them into the rear. Dr. Joseph Y. Porter, the government surgeon in charge of the relief measures in Florida, occupied one of the back seats and Dr. Echemendia of fumigation fame was also of the company.

Councilman Gerow, who was the Acting Mayor in epidemic days, and, like Jim Bludsoe, "seen his duty—a dead sure thing—and went for it, thar and then," sat in the foreground, while Drs. Wakefield, Summers, and numerous others of the gallant home physicians who served the sick through four long months without money and without price, were sprinkled through the audience. The local newspaper men and the correspondents were all there, too, and but for the presence of several citizens who viewed the battle from afar, like "Ancient Priam at the Scæan gate," one might have expected at any moment a telegram of distress from Macclenny, Gainesville, or Fernandina containing the old-time cry to "the men of Macedonia." In fact, McMurray had on his face that old-time look which always preceded the shooting off of

a resolution, and Chairman Wilson of the Committee on Nurses and Medical Attention, appeared to be primed with the customary morning tale from the Medical Bureau. The scene revived many a by-gone memory of the past summer, and as if to complete the picture one lone, solitary, adventurous Minor nurse leaned against the door casing, and one could almost detect a telegram, a communication, or a bill protruding from his inside pocket. Major Durkee, who fought nobly "on the outside," was there, and Captain Talbott, of the Cincinnati contingent, sat quietly against the east wall.

Only a very few suspected the object of the meeting, and they kept discreetly mum. President McQuaid rapped the meeting to order, and the old-timers with one accord involuntarily turned toward Schumacher, expecting him to arise and announce the list of contributions. But the finance chairman didn't move. President McQuaid then stated that the meeting had been called in order to render a proper expression of the feeling of the Association to a gentleman who need not be named, and that the Executive Committee had prepared a report, with suitable resolutions, for submission to the Association. Secretary Charles S. Adams thereupon read the following address and resolutions, submitted by the Executive Committee to the Association:

Jacksonville, Jan. 21.

Mr. President and Members of the Jacksonville Auxiliary Sanitary Association:

Gentlemen: The Executive Committee of the Jacksonville Auxiliary Sanitary Association received on the 18th inst. a communication from Dr. Joseph Y. Porter, surgeon in charge government relief measures for Florida, which recalled the fact that he had consented to take charge of relief measures September 10, 1888, under appointment of Surgeon-General John B. Hamilton, M.H.S., at the earnest request of this Association, seconded by the Duval County Board of Health, and now asks the consent of this Association and the Board of Health to his application to General Hamilton to be relieved from his duties here, in order to obtain rest before resuming the active practice of his profession at his home in Key West.

Your Executive Committee thinks this request, coming from a man who has served the Association, the citizens of Jacksonville, and the State of Florida continuously night and day, without compensation for four months, to the sacrifice of his private business and the loss of his personal comfort, deserves the careful consideration and united action of this Association as a body.

It is impossible, in the nature of the case, for the members of the Association or the citizens of Jacksonville to appreciate, so thoroughly as do the members of this Executive Committee, the scope of the work Dr. Porter assumed in their behalf, or the care and patience which have been exercised by him in executing its details.

At the outset, by the request of the Association and the local authorities, Dr. Porter took charge of all nurses under pay of the government, and soon assumed in rapid succession the command of the sanitary cordon, the control of medical supplies for the indigent sick, the supervision of St. Luke's and the Sand-Hills hospitals, and finally the entire onerous burden of disinfecting every house in this city where a case of yellow fever had occurred. Nor is this all. Besides the work of Jackson-



ville, Dr. Porter directed similar relief measures in Fernandina, Enterprise, Macclenny, Sanderson, and Gainesville. In this position of power and trust, as a medium between the Government of the United States and the citizens of Florida, Dr. Porter has been as loyal to the one as friendly to the other; he has neglected no means, he has spared no labor, that could benefit his fellow citizens, but has at the same time conscientiously and scrupulously guarded the interests of the service he represented.

Your Executive Committee has, so far as possible, lightened the burden and strengthened the hands of our friend, and has noted with admiration throughout the gloom and weariness of the epidemic the executive grasp of the chief, the courteous patience of the gentleman, the sympathetic skill of the physician and the cordial fellowship of the man.

Gentlemen of the Association and fellow citizens, the Executive Committee submits the following preamble and resolution for your action:

*Whereas*, Dr. Joseph Y. Porter of Key West, Florida, is on the eve of severing his official connection with the city of Jacksonville as surgeon in charge of government relief measures in Florida, therefore, be it

*Resolved*, That the unanimous thanks of the Jacksonville Auxiliary Sanitary Association be tendered to him on behalf of the people of Jacksonville, as "one that loved his fellow men, and accepted for their sake a delicate official position during the trying hours of the recent epidemic, and executed the consequent exacting duties to their entire satisfaction at an expense of brain, nerve and health, at a loss of time and money at a sacrifice of individual interests that he alone can fully estimate.

*Resolved*, That an engrossed copy of these resolutions, properly authenticated, be presented to Dr. Porter as the honest expression of our appreciation, gratitude, and respect.

P. McQUAID,  
JAMES M. SCHUMACHER,  
JOHN C. L'ENGLE,  
P. E. McMURRAY,  
W. A. MACDUFF,  
PETER JONES,  
EDWIN G. WEED.

Dr. John C. L'Engle moved the adoption of the resolutions as the sense of the Jacksonville Auxiliary Sanitary Association and the people of the city. He stated briefly that crisis of all sorts bring out the salient qualities of men. In the case of the man whom the Association was about to honor, all the qualities that had come to the surface were the best qualities. Dr. L'Engle acknowledged the obligations which he individually felt to Dr. Porter, because of his kindness and attention to members of his own family, as well as on account of the interest that he felt in common with other citizens in work of a public nature, and he testified to the kindness of Dr. Porter, his uniform equity, and his straightforward dealing in all matters of business.

Mr. P. E. McMurray seconded the resolutions on behalf of the Association, at the same time stating that the words used in the address and by the mover for their adoption showed abundantly the desire of our people to express to Dr. Porter their gratitude. Mr. McMurray recalled the time when Dr. Porter assumed the care that he did, and stated that amidst the pressing calls of an official nature he did not give up his practice as a physician. Mr. McMurray mentioned that he had personally selected two of the fastest horses in the city in order that Dr. Porter might respond, as a physician, at the least possible sacrifice of the time that otherwise was devoted to the public. He stated that to his own knowledge for weeks Dr. Porter labored unceasingly; from twenty to twenty-two hours out of the twenty-four were frequently spent by him in his labor, and when the duties of disinfection were added, and the people of all sorts pressed upon him for payment of claims, he displayed the same equanimity and patience, the same courteous attention throughout; and the citizens and people of Jacksonville would therefore unite in seconding the motion.

Dr. R. P. Daniel arose to say that he was not prepared to make a speech, but did desire to second the resolution. He could add little to the words which had already been said, but he regarded it as a privilege due to him as a lifelong friend of Dr. Porter to express the wish of the citizens present, that all the blessings due to faithful and efficient service might be his.

Mr. D. T. Gerow, formerly Acting Mayor, recalled the advent of Dr. Porter in the city at the time of darkness, and his reception by the few citizens then present, when he first appeared in the rooms of the Board of Trade. He said that when he was introduced by Dr. Mitchell to Dr. Porter, and grasped his hand, he felt that it was the hand of a man who was his friend. Dr. Porter was the first to come of the physicians who had been invited. He may now go from us; his memory and work will remain. He had seen him in the thickest of the fight and he had never left the presence of Dr. Porter without feeling encouraged and strengthened. Only those who had seen him at such time could appreciate his personal qualities, but everyone present could recognize the scope and manner of his work. It is such labor as will last, and never has the city received in dollars and cents from contributions the good it has received from disinfection through the hands of Dr. Porter. Mr. Gerow recalled a question which he had put to Dr. Porter a day or two after the latter's arrival here, and raised the risibilities of his hearers in relating the incident. Upon being asked how many people in a hundred remaining in Jacksonville would be likely to escape the yellow fever, Dr. Porter replied: "About two." "Then put me down as one of the two," had been the acting mayor's request. "To the granting of this request," said Mr. Gerow, "I shall always attribute my escape from the fever."

Mr. B. B. Dillon said that he had no extended remarks to make. He had come without knowing what was to occur, and simply desired to add his testimony for work performed and good wishes for the future.

Dr. Neal Mitchell said that it was impossible for him to let this occasion go by without a tribute to the work of Dr. J. Y. Porter in this city. No one, he said, can fully appreciate this work except those who were in the city and brought in close contact with him. He had known Dr. Porter well personally, and a little in an official way, and he desired, on behalf of the Board of Health, to thank him. While we all appreciate Dr. Porter's qualities as a man, physician and Christian, Dr. Mitchell desired to touch more upon the motive which prompted Dr. Porter to leave his home and come here. He was the first physician to respond to the call for aid, and the first accepted by the Board of Health; and knowing his professional skill and experience in such matters, the members of the board were relieved when they were able to share their burden with him. He occupied a position of power, and at the same time was true to the government and to the people. As he goes to the rest he so well merits, he will carry with him the thanks and blessings of all who know him.

Mr. T. J. Boyd, as one of the nine members of the City Council who remained throughout the epidemic, desired to add his testimony. At the time when the city delegated to Dr. Porter authority, some members of the council thought they were giving into his hands too much power. But he had said then, as he had felt the first time he had looked into the face of Dr. Porter, that he was a man to be trusted, and now that the time of trial is over, he desired on behalf of the City Council to express him the thanks for his good use of the authority thus given him.

Col. John T. Talbott stated that he had not been in the city during the time of the epidemic, but had done his share to furnish the "sinews of war," and as one of the first members of the Association, and as a refugee, he desired to second the motion for the adoption of the resolution.

Maj. J. H. Durkee stated that he, too, was a refugee, and he desired to be heard also, as one who served in the quartermaster's department way back in the rear ranks. It seemed to him that one matter of considerable

importance had been overlooked, and he called the attention of the president and the gentlemen present to the fact that, at the time this Association was making strenuous efforts to obtain from the government the concession that it should pay for the destruction of all property in the disinfection of the city, and he had been requested by the president of the Association to proceed to Washington with other Jacksonville citizens to interview President Cleveland on the matter. He would now state that on their arrival at Washington, they found that the work was almost done, and that there was little for the committee to do in addition. This work had been accomplished by Dr. Porter, and for this, as much as anything, the people of Jacksonville owe him thanks.

Mr. D. T. Gerow stated that he had been requested by Mr. C. Benedict Rogers of South Jacksonville, to say that the short notice of the meeting given did not permit the citizens of South Jacksonville to come over and add their voice to the meeting, but that they had received the same kind of treatment from the hands of Dr. Porter that the people in the city proper had received, and were deeply grateful for the help given them.

Mr. McQuaid then put the question to the Association and asked that it manifest its pleasure by a rising vote. The address and resolutions were unanimously adopted.

President McQuaid then arose and said:

Dr. Porter:

In presenting you these resolutions, which have been adopted as the unanimous sentiment of the members of this Association, and of those most intimately connected with you during our days of trial and sorrow, I will not attempt any fulsome flattery. I know you don't want it, and nothing I could say would impress you more strongly than the words contained in these resolutions of the sincerity of our gratitude and thanks for the inestimable services you have rendered our people in the days of our affliction.

The pleasure incident to this occasion is tempered by the thought that it also reminds us that the pleasant association of the past five months must soon come to an end, when you will return home to the pleasures of your home and family, which you voluntarily gave up to render aid to suffering humanity. You have the assurance that the good wishes and love of the people of Jacksonville go with you, and that your name and work will be remembered in her history.

Dr. Porter came to the front and said:

Mr. President and Gentlemen:

My heart is too full to express adequately the state of my feelings at this moment, but my tongue would certainly be paralyzed if I could not feebly express to the Jacksonville Auxiliary Sanitary Association, the Duval County Board of Health, the city of Jacksonville, and the people resident here, my sincere thanks for the kind words I have heard here. In leaving my home at Key West, I did nothing more or less than my duty as I saw it. I am a native Floridian, and love the state—every inch of her soil. I would go to any other portion of the state as quickly as I came here.

Dr. Porter further stated that by reason of some experience in epidemics heretofore, he could say without egotism that he was fitted to do some good, and whether or not he had done his duty was for others to say. He had been brought into close contact with many Jacksonville people, and had made many warm friends, in the work in which they had mutually shared, by the bed-sides of the sick and dying, and in the interchange of social courtesies. He said now that the work of disinfection was nearly completed in the city, that he trusted the people of Jacksonville would not stop here, but would continue by every possible means to improve the present good sanitary condition of the city. He said in conclusion:

I thank you. As I have been listening here to the many pleasant words which have been spoken I felt as if I had been listening to my obituary. I am afraid that it may make me conceited. My wife thinks I am somewhat conceited now, and I have fears of her opinion on my return home.

President McQuaid then stated that if there was no more business a motion to adjourn would be in order, and was about to put the motion, when Mr. James M. Schumacher arose and stated that he had been so interested in the proceedings, he had been so touched by the solemnity of the meeting and the earnest feeling which the occasion had brought to the surface that he had nearly forgotten an important duty. Mr. Schumacher continued:

What I have to say is what is called by different names; perhaps it would be best to call it a benediction as a clergyman would undoubtedly call it.

Mr. Schumacher then repeated the history of the old woman who arrived at the train to return home after a visit and counted her various parcels and bundles with an uneasy feeling that something had been left, and finally discovered that it was the baby. He was afraid that he had omitted the baby. When things are lost it is customary to advertise in the newspaper "Found," with a description of the article and a possible "reward offered for the return with no questions asked." On behalf of the Executive Committee he desired to save the expense by bringing before this Association an article which had come into his possession in order to try and find the owner. Mr. Schumacher then took up a morocco covered box, and holding it in his hand, said:

Mr. President and Gentlemen:

This box has marked on it the words, "Dr. Joseph Y. Porter," but this is no legal proof that the property belongs to him. I well recall one time during the epidemic when a barrel of select apples came marked to Jas. M. Schumacher, and the Committee on Nurses and Medical Attention consumed the apples. Suppose we look inside. Here is a watch, and on the watch is a capital letter "P," which may stand for philanthropy, or patriotism, or public spirit, or Porter. The metal in the watch is gold, and that represents solid worth. The diamonds upon it represent the motive, the light which illumines the whole. The machinery with its wheels and springs and pivots, represent executive ability; all of which worth, motive, ability, bear testimony to the words on the outside that it properly belongs to Joseph Y. Porter. The charm represents a life preserver, and as I hold it here in my hands I see before me, looking in my eyes, the faces of men who, in the last few months have been on the brink of eternity, and whose presence here is due to Dr. Porter. Yet there was a time when he had no time for such occasions. There was a time when he took all the rest he had in the buggy which carried him from public duty to the bedside of his patient. There was a time when he was surrounded by all kinds of citizens without regard to race, color, or previous condition. Now the clouds have lightened, and he ought to have a good "time," or Messrs. Greenleaf & Crosby are responsible, and should make their guarantee. On behalf of the Association, Dr. Porter, and for the citizens of Jacksonville, I take your hand in mine and say, "Thank you and God bless you."

Dr. Porter arose very much affected, and stated that he could not say more than he had done; that his feelings overcame him and all he could say was to repeat that he had attempted to do his duty, and could simply express his thanks for the kind words which had been said, and for the beautiful gift.

The meeting then adjourned, but scores of the surgeon's admirers and friends crowded about him to express their personal thanks for his services, and to say good-bye. The scene was one long to be remembered, and the whole affair was a notable one in the entire sympathy displayed by all present with the cause which had called them together.

The watch is probably the most elegant one ever brought into Florida, and the accompanying chain and charm are perfect works of art. A full and minute description of the gift, with an accompanying cut, will appear in the columns of the *Times-Union* in a few days.



(From the Florida Times-Union January 22, 1889)

## A FITTING TRIBUTE

Sunday, January 20th, may well be regarded as an important day in Jacksonville's current calendar. It marked the end of the work of disinfection, and ended by the government surgeon under whose charge this had been prosecuted, to declare to his chief, and thus to proclaim to the whole wide world, that the last vestige of disease has been destroyed within the borders of the Queen City of the St. Johns. It was therefore peculiarly fitting that upon the completion of his arduous and self-sacrificing labors, Dr. Porter should become the recipient of the acknowledgments of a grateful people in the form in which these found expression yesterday.

The ceremony was one long to be remembered, for every feature of it exactly fitted the occasion which had called the company together. It was quite remarkable for the consistent sympathy with which everyone present expressed, either by word or look, his high appreciation of the debt which the city of Jacksonville owes Dr. Porter, and which it feels it has but feebly indicated in the resolutions and the gift conveyed to him yesterday. The scene was one half joyful, half pathetic. It brought back the memories of the times that tried men's souls—a period when each day-dawn witnessed a cup quaffed to the living and another raised to the next who should die; when all too often a fond "good night" meant "farewell forever"; and when the pressing duties of the hour were so utterly absorbing that men failed to comprehend the deep significance of the mutual obligations which they were assuming or to quite appreciate the strength of the ties by which mutual trials were daily binding them together. Yesterday's experience brought all of this to the surface and the occasion in reality served a higher purpose than that of honoring the faithful officer who came among us a stranger, and left us more than a friend—almost a brother. Nothing which was said during the ceremonies was fulsome or strained, overdrawn or extraneous. Every man spoke from his heart—and the heart knoweth. As Lord Lytton puts it, "the unities were superb."

In expressing his acknowledgments, Dr. Porter himself, unconsciously perhaps, dropped a text from which the TIMES-UNION would draw a short lay-sermon this morning. He said that he felt as if he were "listening to his own obituary."

It is one of the shortcomings of human nature that we habitually reserve our praise of men until after the earth has closed over them wholly; we can always find sufficient to condemn while life lasts, but when it ceases, *de mortuis nil nisi bonum*. With this tendency still strong within them, it is doubly significant that the men of Jacksonville were yesterday moved to address their benefactor living much as we are wont to speak only of the dead. The compliment was a high and a delicate one, and its sincerity could easily be measured by the thoughtful faces and the moistened eyes which confronted every man who arose to record his official or his personal sense of obligation.

In this connection it may not be unfitting that the TIMES-UNION convey to Dr. Porter its own appreciation, and that of the press in general, of the substantial and constant aid which he extended to the many newspaper representatives in Jacksonville, cheerfully imparting to them vast amounts of interesting information which he always had in store. Almost from the day of his arrival here he became perforce "a channel of news," and the voracious journalist regarded him as his special prey. With what degree of dignity, tact and courtesy he allowed himself to "be brought down," the score of them can testify. If ever in a single instance the relations of mutual respect and friendship became in the slightest degree strained, yesterday healed the wound forever. In leaving Jacksonville Dr. Porter parts with friends. He and the people whom he served so long and well can never lose fealty.

(To be Continued)

## STATE BOARD OF HEALTH NOTES

In order that those who desire it may have individual protection from diseases for which active immunization is possible and practicable, the State Board of Health plans to offer free smallpox vaccination, typhoid inoculation, Schick testing and toxin-antitoxin injections in as many communities as can be served during the coming year.

Already this service has been offered in a small way in a number of counties during the spring and summer months of this year and numerous expressions from physicians and laymen indicate that the work is looked upon with favor.

It is a common experience that the number of immunizations given by local physicians is greater during and after the visit of the district health officer than it was before, and that through this combined effort a very considerable portion of the population acquires protection.

The work is accomplished most effectively while the schools are in session because the children are most benefited by the service, are most easily reached and the necessary preliminary information is readily disseminated through them. Advantage is often taken of public interest in preventive measures by putting on the program when a case of communicable disease appears in a community. Any physician desiring this service for his town or county should, while on his daily rounds, speak to his patients of its value. The Director of the Communicable Disease Bureau would welcome any communication inquiring about the program or requesting the service of a district health officer to put it over.

It is the hope and belief that this program will have the hearty support of the medical profession and become increasingly effective in reducing the sickness and death rates from three preventable diseases—smallpox, typhoid and diphtheria.



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## THE SCIENTIFIC PROGRAM

The work of preparing a most excellent scientific program for our next annual meeting is already under way. The committee is beginning the work earlier this year than usual in order that a diversity of subjects and all sections of the state may be represented. They are particularly anxious that those members of the association who wish to present papers communicate with them, giving subject and an abstract of the subject material. The program will be limited in order that there may be no conflict of time. Those desiring to present papers are urged to communicate with the chairman of the

committee, Dr. Frederick J. Waas, Professional Building, Jacksonville.

## RECIPROCITY

For several years our State Board of Medical Examiners has been besieged with requests for professional reciprocity, coming as a whole from practically the entire country. When informed that the Board cannot extend the privilege of reciprocity, protests and criticisms have resulted which in the main have been directed at the Board apparently without any attempt being made to ascertain the cause of its actions, and without any other than wholly selfish motives actuating them.

A defense of the Board's position and of that of Organized Medicine as a whole in this state is now timely, especially in view of the state's very rapid growth and nation-wide interest manifested in it during the past few years.

Florida is peculiarly situated. Our state is undoubtedly the principal winter playground of the nation. Moreover, it is in many ways the favored location for convalescents, chiefly due to its matchless climate. Years ago Organized Medicine found it necessary to adopt high standards for admittance to practice medicine in the state. It was found to be necessary as a measure of self protection and public welfare to admit only on examination by the board. The reasons are at once obvious.

Reciprocity would make the state available during the winter season to all comers, the Board having no control whatever as to qualifications of applicants, who could come into the state for the winter months and thereafter disappear. Those not qualified, but holding old licenses from any other state could immediately enter this state without any control whatever by the Board.

A uniform, impartial law governing medical practice was imperative. Such a practice act was enacted by our State Legislature. Under it the Board was authorized to set certain high standards to be met by all seeking to practice in Florida, whether they be lifelong residents, taxpayers, and legal voters, or strangers from any part of the world. The Board was given specific regulations to follow, and it has followed them.

Examinations are given by the Board which can be taken successfully by any one from an A-Class medical college, the applicant being of good moral standing and reasonably informed

in the progress of his profession if his graduation dated back many years. They cannot be taken successfully by one not from an accepted institution, nor by one whose credentials, upon scrutiny, are found to be unsatisfactory, or prove, as has several times occurred, to be spurious.

Contrary to the opinions of many who seek to practice in our state, the motives behind the Board's actions are not selfish. The public has been primarily considered. This statement is seen to be not controversial if one will simply remember that any and all of those desiring to enter practice in Florida need only conform to regulations established for their own good after they enter the state; regulations to which those entering them have conformed, and which certainly work not the least hardship upon those really qualified to enter our state. Those seeking to become permanently associated with organized medicine in Florida should be as zealous in maintaining its high standards before they enter as they are sure to be afterwards. We welcome them into the state on such a basis. May they all see our viewpoint before they appear for qualifying examinations, as they invariably see it after they have conformed with our regulations and are one of us.

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### CONCERNING THE AVERAGE CITIZEN

With an increase in hospitals and hospital facilities throughout the country there has developed a growing tendency for people to hospitalize their sick. The rich are able to command all the high-class service of a well ordered institution with no particular drain on their resources, and even a long drawn illness causes no financial difficulty. Likewise the poor who are forced, and often willing, to accept charity for the sick of their families, go through a hospital experience no worse at the end than at the beginning. However, the average citizen who is able and ready to pay moderately, and who is unwilling to accept charity, finds it impossible to meet, for a continued period, the expenses incident to present-day hospital sickness.

Our hospital program at present covers the extremes of financial ability but takes insufficient account of that element which constitute the bulk of practice; the average citizen. If the hospital collects promptly and completely his finances are soon exhausted and the attending physician or surgeon must wait indefinitely or fail to collect

entirely; if the doctor demands or receives payment in advance there remains insufficient for the hospital and nurse's bill; in either case there results an unhappy situation which too often leaves the patient and his family with the feeling of having been handled with scant consideration.

It is believed that more intelligent handling of the average citizen would result in a wider appreciation of hospital service and more effective co-operation between doctors and institutions. The use of small wards on a floor not stigmatized by the word "charity", where visiting hours would be identical with those rooms of higher price, the employment of senior student nurses for critical periods in an illness, and a doctor's fee in keeping with the hospital accommodations, have been suggestions successfully carried out in the interests of that majority in any community, the average citizen.

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### CHOLECYSTOGRAPHY

The direct visualization of the gall-bladder rendered opaque to the X-ray by means of a dye excreted in the bile, promises to lead the way through the haze of uncertainty surrounding the roentgenological diagnosis of gall-bladder disease. Cholecystography is now being worked out and thoroughly tested by roentgenologists, internists and surgeons throughout the country.

The fundamentals of the test call for the administration of a dye intravenously or orally and making a series of gall-bladder films subsequently at stated hours. In this way the behavior of the gall-bladder before, during and after digestion can be accurately observed. For success the dye must fill the following requirements: Be excreted almost entirely in the bile, be collected and concentrated in the gall-bladder, be non-toxic and of sufficient atomic weight to cast a dense shadow on the X-ray film.

The test was first introduced by Drs. Evarts A. Graham and W. H. Cole of the Surgical Department, Washington University School of Medicine in 1923. At present it seems to be generally conceded that the intravenous method gives uniformly better results.

Under most favorable circumstances and with the greatest care, the usual X-ray methods of examination of the biliary tract have been but thirty-seven per cent correct when checked by operation, while with this method of clearly visualizing the gall-bladder, the percentage of cor-

rect diagnoses has been increased to ninety-four per cent in the hands of reliable workers. These figures speak for themselves. Cholecystography seems to promise one of the greatest contributions to roentgenology in recent years.

### RECORDING DATA

Records are of value if they are accurate, legible, and capable of interpretation by others than those making them. It is so important to record findings that any discussion in its favor should be unnecessary. Most of us are willing to spend hours in consultation but refuse to give moments to make those observations useful to others. They contend we are healers of the sick, not scribes.

One fault probably lies back in our training days when we looked upon records as important, but making them not within the medical profession. As we began to practice with limited work, many details could easily be remembered, so carelessness crept in and later in the busy days we didn't find time to become clerical.

Negligence and indifference toward recording data is a common fault of the profession even though we are convinced of its value. Patients are pleased when the doctor is familiar with past conditions and can refer to an old card that recorded some special observation. Added confidence is imparted and he feels like his last complaint was of sufficient importance to impress the doctor. Even the doctor's services are worth more.

To the layman they mean that much, to the doctor a great deal more. They are a bibliographical record of his medical past. The patient's memory of past conditions then does not play such an important part—the recorded observation is the valuable data.

### THE NEW SECTION ON RADIOLOGY

It is of interest to note that this year, the thirtieth anniversary of the discovery of the Roentgen ray, the American Medical Association created a section of Radiology. It is late recognition of an important department of medicine. Roentgenology has long since arrived and as practiced on the highest plane, deserves the recognition granted. Its recognition will help and assist in the future of this important branch of medicine. As a branch of Medicine it should be so controlled by law as to regulate its use in a proper manner.

### STATE NEWS ITEMS

*This department is supervised by Dr. Ralph N. Greene, Jacksonville. Members of the State Association are requested to forward to Dr. Greene or the Editor such news items as they may think of interest to the readers of THE JOURNAL.*

Dr. J. C. Vinsen of Tampa is touring the West this summer. He expects to return to Tampa sometime this month.

Dr. and Mrs. S. A. Scruggs have just returned from a vacation spent in the mountains of North Carolina.

Dr. H. F. Watt of Ocala was recently called to the bedside of his mother, who is seriously ill at her home in Chicago, Ill.

News has just been received of the painful injury of Dr. W. K. Lane of Ocala, who is at this time touring in Pennsylvania.

Dr. Edward Jelks, Riverside Hospital, Jacksonville, has recently returned from a visit to a number of important European medical centers. The editor of this department will "keep his ear to the ground" in an effort to determine important observations made by Doctor Jelks and will give the profession of the state the "low down" in a subsequent issue. This is not a threat and refers only to observations in the field of surgery. Any recreational activities of our Florida doctor (European tourist) will not be "written up" for the gossip would never get by the blue pencil of the editor "nohow."

Dr. T. H. Bates of Lake City, as a captain, Medical Officers Reserve Corps, has recently completed a tour of duty at Fort Scriven, Ga. Doctor Bates is an enthusiastic member of the American Legion and is prominent in the state affairs of this body.

Dr. R. F. Goddard of Quincy recently presented the leading paper at the meeting of the district medical society held at Quincy. Doctor Davis, Quincy, acted as toastmaster at the banquet which followed and presided in a charming and mellifluous manner. The principal address of the evening was made by Dr. J. Q. Folmar, chief of staff at the State Hospital, Chattahoochee.

Dr. S. E. Driskell of Jacksonville continues to care for the obstetrical practice at the home for delinquent girls, Volunteers of America. The service has been brought up to a high degree of efficiency, appeals tremendously to those who are interested in human unfortunates. The work is

(Continued on page 79)





DR. GILBERT H. HODGSON

On July 22nd, 1925, Dr. Gilbert Haven Hodgson of Tampa, Florida, died in Asheville, North Carolina, after a somewhat extended illness. Dr. Hodgson had been in Asheville for his health for about two months.

Gilbert Haven Hodgson was born in Albion, Ill., April 19th, 1888. He attended the Southern Collegiate Institute of that place, and the University of Illinois. He graduated from the St. Louis Medical University in 1911, after which he served as an interne in St. Luke's Hospital, Cleveland, Ohio, for eighteen months.

In 1912 Dr. Hodgson began the practice of medicine in Tampa, limiting himself to Urology. In 1918 he entered the Medical Department of the navy and was stationed at Key West during his entire service.

Soon after his discharge from the navy Dr. Hodgson's health began to fail and in 1920 he closed his office in Tampa and spent four years in the West, returning in 1924 to resume his practice.

Dr. Hodgson had been a member of the Hillsborough County Medical Society since coming to Tampa and for five years he served as Secretary. He was an accomplished musician and possessed a magnetic personality. He was a Scottish Rite Mason, a member of Egypt Shrine Temple and was held in high esteem as a citizen of Tampa. He is survived by his wife, Mrs. Elizabeth Hodgson, and three daughters, Eleanor, Betty and Julia, and by his father and mother, Mr. and Mrs. E. S. Hodgson, all of whom reside in Tampa.

(Continued from page 77)

carried out by Doctor Driskell under stress of financial shortages and even so, the accomplishments stand as a monument to the fidelity of a doctor who seems not to be entirely absorbed in the task of attending pay patients.

Jacksonville is mentioned several times in this issue because of lack of news items. If the doctors over Florida will just pen a few lines about the tenth of each month for this department we will have less necessity for mentioning news items from the place wherein we live.

All doctors who have been interviewed seem to think THE JOURNAL is getting more valuable each month. Subject matter is necessary. Even though the writer of this department's subject-matter will be green with envy and bowed with sorrow, news of the wonderful profits in real estate will be mentioned. I saw a doctor recently who assured me he had a sure competency for the balance of his life made on real estate. Send me your checks for a dollar, payable to the Florida Medical Association and I will tell you in just what portion of Miami, Palm Beach, Tampa or Jacksonville the doctor invested in "acreage."

Miss Ainah Boyce has confirmed her resignation as superintendent of The Jackson Memorial Hospital, Miami. Miss Boyce is concluding twenty-nine continuous years of nursing and will spend the balance of the summer in New York, returning to Miami in the fall.

Dr. John F. Breshnahan has been appointed superintendent of the Jackson Memorial Hospital, Miami. Doctor Breshnahan is a graduate of the University of Pennsylvania and also of the course in hospital administration at the Massachusetts General Hospital. During the war the doctor was a major in the research corps and is a graduate of the field medical school of the army.

Dr. and Mrs. Harold G. Fox of Miami sailed from Miami to Philadelphia on August 1. The Doctor will take post-graduate work in the East and Middle West, returning to Miami about the middle of October. Mrs. Fox and the children will motor through the eastern states while the Doctor is attending lectures and clinics.

Dr. Leon H. O'Quinn of Hialeah and Miss Pauline Fauss of Georgia were married at Hialeah on August 2nd. Doctor O'Quinn is associated with Dr. R. J. Lamb.

Dr. O. G. McKenzie of Miami, recently left Hendersonville, N. C., proceeding to New York and Philadelphia where he will take post-gradu-

ate work. He will return to Miami in the early fall.

Dr. and Mrs. John Keely of Miami are enjoying a summer vacation in Saranac, Lake Placid, New York and Philadelphia. They will return to Miami in early October.

Dr. and Mrs. J. E. Marshall of Miami will return from an Eastern summer vacation in November and will make their home in the Bay View Apartments, Miami.

Dr. and Mrs. J. Roy Hawkins and little son have recently returned from a visit with the Doctor's parents at Williston.

Dr. and Mrs. Stewart L. Jeffrey are recreating in and around New York City and will return to their Coconut Grove home in a few weeks.

Miss Portia Keeler, daughter of Dr. and Mrs. Keeler of Miami, will attend Shorter College, Lakeland, this winter. Mrs. Keeler's sisters, Mrs. Edith Moore of Chicago and Miss Katherine Moore of Pittsburg, have been guests at the home of Dr. and Mrs. Peeler of Miami.

Dr. G. H. Benton was a visitor at Winter Haven recently, having been called on professional business. Doctor Benton plans to spend the summer in the mountains of North Carolina (September only). Dr. J. W. Mehaffey of Supply, Oklahoma, will care for the Doctor's practice and will probably remain in association with Doctor Benton permanently as a neuro-psychiatrist. It is said Miami and South Florida have gone wild over real estate but no longer do we hear the howling for another insane asylum there.

Dr. Benjamin F. Barnes, Chattahoochee, was a recent visitor at the Fleetwood Hotel broadcasting station, Miami Beach. Doctor Barnes has received daylight radio at Chattahoochee, a location with about the highest elevation in Florida and far removed from interferences such as are encountered in urban centers. Doctor Barnes enjoyed an auto trip throughout South Florida as a part of his annual vacation.

Capt. William C. Munly, Medical Corps, United States Army, has recently completed a course in cardiology, presented by himself to a group of Jacksonville physicians. Captain Munly is instructor in cardiology at the school of aviation medicine, Mitchell Field, Long Island, N. Y., and is connected with the cardiology clinic at the Bellevue Hospital, New York City. Captain Munly was trained for a number of years under McKenzie and Lewis in England. His lectures



were absorbingly interesting and helpful to the doctors in attendance. The work included broad instruction in bedside methods of diagnosis and the use of electrocardiographic means of interpretation. The monthly staff meeting at St. Luke's consisted of a lengthy lecture on the treatment of heart diseases and was largely attended.

Dr. Francis A. Copp, acting assistant surgeon, United States Public Health Service, has resigned for the purpose of training in dermatology. He plans to go to Vienna within a year for post-graduate instruction. Dr. Adolphus K. Wilson will likely accompany Doctor Copp for the purpose of special eye, ear, nose and throat study.

Dr. Gerry R. Holden was a recent visitor in Miami. He has about concluded that he really saw wonders although it was difficult to believe his eyes. The terms Miami and Florida seem to convey the same meaning throughout the United States.

Dr. Joseph N. Fogarty, chief surgeon, Florida East Coast Railway, returned recently from a vacation in New England and Canada. With increased activities in railway circles Doctor Fogarty will no doubt soon long for another vacation. It is terrible to be poor. Being wealthy, Doctor Fogarty is spared this agony.

Doctor Caldwell, clinical director, U. S. Veteran's Bureau Hospital, Lake City, is in Boston, Mass., taking special training in cardiology. A modern electrocardiograph is being installed at the Lake City Hospital for Doctor Caldwell's use after his return.

Dr. F. C. Keisling, Jacksonville, is pursuing some investigations relative to chyluria, having recently encountered a case of this rare condition.

Dr. N. A. Baltzell, member of the State Board of Medical Examiners, residence, Marianna, was a recent visitor at Tampa. It is said he purchased a fine leather Gladstone bag while there. It is probable that the Doctor had to secure extra luggage to carry the examination papers home. There was a class of some two hundred and fifty applicants for license, a group said to have been composed of highly trained medical men, prospective citizens of Florida.

Dr. H. Mason Smith, Tampa, was a recent "passer-thru" in Jacksonville. Doctor Smith has a recent commission as a member of the State Board of Health. It is said he has writer's cramp from signing deeds in the transfer of his numerous real estate holdings and last but not least has

not been married long enough yet to have eradicated the signs of being a newlywed. His charming home in Suburb Beautiful is a delight forever. Again it may be mentioned that being poor is a novelty.

Elsewhere appears the notice of the sad death of one of our Florida doctors. A majority of the estates of doctors are so small that inadequate means for partially replacing the earning capacity of the deceased seriously jeopardizes the education of the children. Some doctor among the membership of the Florida Medical Association could earn eternal fame for himself if he would develop a plan whereby the profession of the state could be allowed to contribute a few dollars every time a member dies, said fund to apply to the education of a dependent child. The State Board of Medical Examiners has a fund to be used for the education of some worthy young man. Doubtless this board could be influenced to apply the funds, as a nucleus for a state medical society fund. Our worthy president and his executive committee might be interested.

Dr. G. C. Tillman of Gainesville was elected president of the Atlantic Coast Line Railway Surgeons at the annual meeting held at Wrightsville Beach, N. C., the meeting being held in June.

Dr. Merrick D. Thomas has recently returned from Alabama, where he spent a vacation with his distinguished relatives, Judges W. H., C. E. and Y. R. Thomas, Montgomery. Few families in America can boast of three judges and two doctors. Dr. Edwin C. Thomas, another doctor member of the family, is now on a vacation trip to Alabama.

Dr. H. B. Cordes, Frostproof, motored North with Col. and Mrs. Walter P. Corbett. While in New York the Doctor attended a six-weeks post-graduate course at the Polyclinic Hospital. Following this the pleasures of golfing and a visit with relatives at Springfield, Mass., were terminated by the necessity for an operation, from which Doctor Cordes is now convalescing. Doctor and Mrs. Herman Watson of Lakeland visited Doctor Cordes while en route to Europe. Doctor Cordes will return to Florida in early October, after the completion of additional study.

The 116th Field Artillery entrained at Tampa for summer training at Fort Bragg, N. C. Maj. Earle H. McRae is the regimental surgeon. The other commissioned medical personnel is Capt. Bevis, Arcadia, Capt. George E. W. Hardy,



Tampa. The dental officer is Capt. A. M. Smith. Tampa. The veterinarian is Captain Martin of Lakeland. Two weeks of training at Fort Bragg is the programme of the military authorities. Mrs. E. W. Hardy presented Doctor Hardy with an eight-pound boy on July 19th. General Sherman was right. Nevertheless the many friends of Doctor Hardy will be interested to know of the babe's arrival and wish the parents much happiness.

The 124th Infantry has terminated the annual training tour at Camp Johnston, Jacksonville. Majors Klock and Henson and Capt. A. C. McKenzie were the medical officers' personnel.

Dr. Frederick J. Bowen of Jacksonville has returned from an extensive tour through Canada, the Northwest and California. The Doctor visited a number of important medical centers while away, bought a new eight-cylinder automobile (trading in the old bus) and like other touring Floridians was kept busy assuring the wondering populace that the stories about Florida are really true.

Dr. B. L. Arms was recently appointed to succeed Dr. Raymond C. Turck as State Health Officer of Florida. Doctor Arms has had a long experience in health activities, has witnessed the efforts of at least three health officers and should carry out a health effort that will be sane and constructive. The writer was once State Health Officer. The position is not an easy one. The doctors of Florida should aid Doctor Arms in putting into effect his ideas, the principal one of which is doubtless the development of county health units for all sections of the state. Col. Raymond C. Turck, the retiring health officer, will devote his time to his numerous and extensive business interests.

Dr. M. B. Herlong, city commissioner of Jacksonville, will sail for France on September 15th. He will represent Jacksonville at the meeting of the International Congress of Cities. He will make an extensive tour of the continent for the purpose of observing municipal activities. Doctor Herlong is the health commissioner of Jacksonville and will utilize his time and effort in gaining information along lines of health and sanitation, particularly in tourist communities. Doubtless the Doctor will return with constructive ideas from which the entire state of Florida will profit. Doctor Herlong is a trusted public official, a keen observer and endowed with aggressiveness which has resulted in winning for him-

self an enviable place of esteem among his fellow-citizens.

Major Stephens of DeLand was recently on a two-weeks tour of duty with the National Guard troops at Camp Johnston.

Dr. Paul T. Butler and family have recently purchased an attractive home at 216 Park Lake Avenue, Orlando, the home being located in a very desirable and exclusive residential district. The Doctor formerly resided in a beautiful rural home but the trials and tribulations of practice made an urban home a necessity.

Mrs. Dr. L. A. Likkenga and little son, Albert Leon, of London, England, will soon visit Orlando for a period of several months, visiting Mrs. Likkenga's parents, Dr. and Mrs. Paul Butler.

Dr. E. K. Jaudon of 404 N. E. 27th street, Miami, is reported under date of August 22nd as now being satisfactorily convalescent from his recent serious illness. This is good news.

Dr. C. J. Heinberg, a former resident of the North Chicago Hospital, is now completing some post-graduate work in ophthalmology and otolaryngology in New Orleans. He will return to Pensacola this fall to practice.

The many friends of Dr. A. M. Ames of Pensacola sympathize with him in the loss of his mother.

Dr. C. Hutchinson is spending his vacation in Chicago.

Dr. and Mrs. M. A. Lischkoff of Pensacola are leaving for Chicago where they will remain for the meeting of the American Academy of ophthalmology and oto-laryngology.

Pensacolians are particularly pleased over the appointment of Dr. W. D. Nobles on the State Board of Health. One of Dr. Nobles' first acts was to declare war on mosquito breeding places.

The following physicians took the Florida State Medical Examination, June 15-16, 1925, at Tampa, and received a passing mark:

Dr. John H. Copper, Commerce, Georgia.  
 Dr. T. W. Taylor, Dozier, Alabama.  
 Dr. A. W. Wood, Albany, Georgia.  
 Dr. E. F. Sapp, Albany, Georgia.  
 Dr. E. C. Newell, Albany, Georgia.  
 Dr. H. C. Pattengill, Fairfield, Maine.  
 Dr. Hobart R. Hunter, Elkhart, Illinois.  
 Dr. Jesse H. Strickland, Norfolk, Virginia.  
 Dr. A. J. Bryan, Tampa, Florida.  
 Dr. Thomas B. Echard, Connelssville, Pennsylvania.  
 Dr. H. A. Walter, Indianapolis, Indiana.  
 Dr. Franklin Thorpe, Tampa, Florida.  
 Dr. Horace J. Williams, Tampa, Florida.  
 Dr. J. R. Simpson, Gainesville, Georgia.

- Dr. Clifton M. Rosin, New York, New York.  
 Dr. C. Casper Method, Chicago, Illinois.  
 Dr. Robert W. Preston, Charleston, S. C.  
 Dr. J. Gillis Sanders, Troy, Alabama.  
 Dr. John J. Roy, Sydney, N. S.  
 Dr. Edward E. Campbell, Logan, Ohio.  
 Dr. George L. Bates, Morrisville, Vermont.  
 Dr. George R. Christian, Tampa, Florida.  
 Dr. A. T. Roope, Columbus, Indiana.  
 Dr. J. C. Hayward, St. Louis, Missouri.  
 Dr. Thomas E. Scott, Lexington, Illinois.  
 Dr. Frank E. Kauffman, Lake City, Iowa.  
 Dr. Robert P. Henderson, Tampa, Florida.  
 Dr. J. M. C. McAllister, Rochelle, Georgia.  
 Dr. William E. Quicksall, Philadelphia, Pennsylvania.  
 Dr. Shelley C. Davis, Atlanta, Georgia.  
 Dr. Louis M. Smith, Miami, Florida.  
 Dr. Lynn Fort, Jr., Atlanta, Georgia.  
 Dr. Alfred G. Nast, Miami, Florida.  
 Dr. Sylvester Cain, Jr., Atlanta, Georgia.  
 Dr. James F. Crow, Atlanta, Georgia.  
 Dr. Harold P. McDonald, Atlanta, Georgia.  
 Dr. H. G. Holland, Atlanta, Georgia.  
 Dr. J. K. Outlaw, Mulberry, Florida.  
 Dr. J. A. Ilderton, Gamason, South Carolina.  
 Dr. Benjamin J. Martin, Bemidje, Minnesota.  
 Dr. M. W. Kneeder, Pittsburg, Pennsylvania.  
 Dr. G. W. Blackshear, New Orleans, Louisiana.  
 Dr. C. F. Lewis, Atlanta, Georgia.  
 Dr. J. I. Thorne, Miami, Florida.  
 Dr. E. B. Hardee, Sebastian, Florida.  
 Dr. Hugh McCulloh, Jr., Atlanta, Georgia.  
 Dr. H. H. Askeew, Atlanta, Georgia.  
 Dr. Sergio S. Pena, Atlanta, Georgia.  
 Dr. Leon O. Davis, Miami, Florida.  
 Dr. Earl C. McCordy, Clearwater, Florida.  
 Dr. Julien C. Pate, Macon, Georgia.  
 Dr. Virginius L. Brown, Fort Valley, Georgia.  
 Dr. Oliver L. Sharp, Greensboro, North Carolina.  
 Dr. P. J. Manson, Miami, Florida.  
 Dr. Hubert A. Barge, Miami, Florida.  
 Dr. W. J. Barge, Miami, Florida.  
 Dr. John Banks, Miami, Florida.  
 Dr. Ollie C. Brannen, Columbus, Georgia.  
 Dr. C. E. Rushin, Atlanta, Georgia.  
 Dr. Arthur G. Fort, Atlanta, Georgia.  
 Dr. J. W. Ratliff, Atlanta, Georgia.  
 Dr. William O. Martin, Jr., Atlanta, Georgia.  
 Dr. A. S. Weekley, Bamberg, South Carolina.  
 Dr. T. M. Stuckey, Cope, South Carolina.  
 Dr. Gordon G. Allison, Atlanta, Georgia.  
 Dr. George H. Alexander, Atlanta, Georgia.  
 Dr. James S. White, Atlanta, Georgia.  
 Dr. J. O. Barfield, Atlanta, Georgia.  
 Dr. John R. Boling, Columbia, South Carolina.  
 Dr. Thomas A. Pitts, Columbia, South Carolina.  
 Dr. F. A. Vogt, Atlanta, Georgia.  
 Dr. W. P. Duncan, Jr., Jersey City, New Jersey.  
 Dr. John B. Milton, Bluefield, West Virginia.  
 Dr. L. W. Blake, Bradenton, Florida.  
 Dr. Emmett M. Martin, Waycross, Georgia.  
 Dr. W. H. Groves, Waycross, Georgia.  
 Dr. T. C. Williams, Atlanta, Georgia.  
 Dr. Leonard T. Furlow, Atlanta, Georgia.  
 Dr. Mark Byrd, Atlanta, Georgia.  
 Dr. E. F. Fincher, Jr., Atlanta, Georgia.  
 Dr. D. H. Grimes, Miami, Florida.  
 Dr. L. F. Robinson, Hartford, Connecticut.  
 Dr. Max S. Rabinowitz,  
 Dr. Ernest D. Resink, New Haven, Connecticut.  
 Dr. Colquitt Pearson, Jessup, Georgia.  
 Dr. Paul H. Martin, Jacksonville, Florida.  
 Dr. S. A. Clark, Eatonton, Georgia.  
 Dr. A. F. Quillian, Atlanta, Georgia.  
 Dr. R. H. Stovall, Macon, Georgia.  
 Dr. J. W. Cheney, Wichita, Kansas.  
 Dr. E. K. McLean, Thomasville, Georgia.  
 Dr. S. L. Cheshire, Thomasville, Georgia.  
 Dr. Benjamin H. Burgner, Chicago, Illinois.  
 Dr. C. R. Koffman, Fort Lauderdale, Florida.  
 Dr. E. Rankin Denny, Fort Lauderdale, Florida.  
 Dr. F. M. Woodall, Chattahoochee, Florida.  
 Dr. F. Raymond Price, Charleston, South Carolina.  
 Dr. W. E. Burnett, Philadelphia, Pennsylvania.  
 Dr. William N. Parkinson, Philadelphia, Pennsylvania.  
 Dr. Jesse H. York, Atlanta, Georgia.  
 Dr. Elbert McLaury, Atlanta, Georgia.  
 Dr. Milton C. Smith, Mt. Clemens, Michigan.  
 Dr. Oscar White, Memphis, Tennessee.  
 Dr. C. Alfred Brown, Derby, Connecticut.  
 Dr. James W. Smith, Manila, Philippine Islands.  
 Dr. George W. Brown, Lawty, Florida.  
 Dr. Andrew H. Fowler, Augusta, Georgia.  
 Dr. E. Lucille Johnson, Chicago, Illinois.  
 Dr. Walter J. Sullivan, Chicago, Illinois.  
 Dr. John H. Franklin, Spring Valley, Illinois.  
 Dr. R. Henry Baldwin, Atlanta, Georgia.  
 Dr. Athens V. Lodge, Kansas City, Missouri.  
 Dr. John A. Coleman, Richmond, Virginia.  
 Dr. W. L. A. Wellbuck, Charleston, South Carolina.  
 Dr. Quintard Taylor, White Sulphur Springs, West Virginia.  
 Dr. Ernest Bostelman, Fort Myers, Florida.  
 Dr. A. R. Knauf, Milwaukee, Wisconsin.  
 Dr. J. A. Davila, Jacksonville, Florida.  
 Dr. D. P. Broadbent, Jacksonville, Florida.  
 Dr. Samuel E. Field, Woodward, Alabama.  
 Dr. Geo. E. Sanders, Des Moines, Iowa.  
 Dr. James F. Alison, Fairfield, Alabama.  
 Dr. J. Raymond Graves, Savannah, Georgia.  
 Dr. T. J. Kemp, St. Louis, Missouri.  
 Dr. A. E. Rogers, St. Augustine, Florida.  
 Dr. Thomas W. Morgan, Virden, Illinois.  
 Dr. Richard S. Gill, West Palm Beach, Florida.  
 Dr. Thomas H. Odeneal, Beverly, Massachusetts.  
 Dr. W. H. McLarty, Ojus, Florida.  
 Dr. Arthur E. Smith, Chicago, Illinois.  
 Dr. B. A. Wilkinson, Alton, Florida.  
 Dr. F. B. Threatte, Columbus, Georgia.  
 Dr. J. W. Chambliss, Americus, Georgia.  
 Dr. Claude F. Fleming, Minneapolis, Minnesota.  
 Dr. Louis Caplan, Miami, Florida.  
 Dr. John A. Mease, Jr., Richmond, Virginia.  
 Dr. K. P. A. Taylor, Philadelphia, Pennsylvania.  
 Dr. James W. Payne, Americus, Georgia.  
 Dr. W. H. Garlington, Birmingham, Alabama.  
 Dr. C. H. Knauer, Schuylkill Haven, Pennsylvania.  
 Dr. Thomas Sims, Birmingham, Alabama.  
 Dr. Frederick F. Kumm, St. Petersburg, Florida.  
 Dr. W. H. Watters, Boston, Massachusetts.  
 Dr. W. L. Ashton, Reynoldsburg, Ohio.  
 Dr. W. W. Hall, St. Louis, Missouri.  
 Dr. L. E. Roper, Holleywood, Florida.  
 Dr. M. F. McRae, Milwaukee, Wisconsin.  
 Dr. Nelson M. Black, Milwaukee, Wisconsin.  
 Dr. B. L. White, Round Oak, Georgia.  
 Dr. Alfred B. Owen, Chicago, Illinois.  
 Dr. L. B. Tyler, Hephzibah, Georgia.  
 Dr. Timothy Leary, Boston, Massachusetts.  
 Dr. Arthur P. Jaues, Boston, Massachusetts.  
 Dr. F. M. Causey, Lakeland, Florida.  
 Dr. F. M. Hand, Atlanta, Georgia.  
 Dr. Zack W. Jackson, Atlanta, Georgia.  
 Dr. L. M. Sanders, Troy, Alabama.  
 Dr. Frank Foxworthy, Indianapolis, Indiana.  
 Dr. I. W. Voorhees, New York City.  
 Dr. Robert Pillow, Jr., Brewster, Florida.  
 Dr. M. Walton, Lumpkin, Georgia.  
 Dr. M. W. Spearman, Chickamauga, Georgia.  
 Dr. Chester C. Box, Lake City, Florida.  
 Dr. I. A. Black, Lake City, Florida.  
 Dr. James H. Dyer, Lake City, Florida.  
 Dr. William B. Ryan, Jr., Beaufort, South Carolina.  
 Dr. Wilson C. Pay, DeLand, Florida.  
 Dr. Jesse Newman McLane, Pensacola, Florida.  
 Dr. Walter M. Lott, Waycross, Georgia.

Dr. Charles J. Collins, Savannah, Georgia.  
 Dr. B. Y. Pennington, Atlanta, Georgia.  
 Dr. Alva A. Knight, Chicago, Illinois.  
 Dr. H. G. Branham, Okahumpka, Florida.  
 Dr. Ralph B. Lingeman, Fort Lauderdale, Florida.  
 Dr. E. P. Harrell, Augusta, Florida.  
 Dr. M. M. Marr, Richmond, Virginia.  
 Dr. W. N. Macastery,  
 Dr. Ray R. Harris, Dubuque, Iowa.  
 Dr. Henry A. Klusman, Toledo, Ohio.  
 Dr. Oliver C. Brown, Charleston, Illinois.  
 Dr. Fred H. Albee, New York City.  
 Dr. Isaac D. White, Clinton, Indiana.  
 Dr. J. A. B. Sinclair, Miami, Florida.  
 Dr. Milton M. Coplan, Birmingham, Alabama.  
 Dr. Randolph Dade, Hopkinsville, Kentucky.

Dr. William C. Bayless, Jacksonville, Florida.  
 Dr. George I. Cook, Atlanta, Georgia.  
 Dr. Ed. S. Nichol, Chicago, Illinois.  
 Dr. Fred Y. Durrance, New Orleans, Louisiana.  
 Dr. Vance W. Fletcher, Greensboro, Florida.  
 Dr. T. E. Buckman, Boston, Massachusetts.  
 Dr. Frederick A. Smith, Jacksonville, Florida.  
 Dr. Thomas G. Jenny, Pittsburg, Pennsylvania.  
 Dr. W. C. Moser, Morgantown, West Virginia.  
 Dr. J. L. Summerlin, Gainesville, Florida.  
 Dr. C. L. Drew, Waycross, Georgia.  
 Dr. H. C. Nash, Hamilton, Canada.  
 Dr. Oscar B. Beer, Buckhannon, West Virginia.  
 Dr. James A. Rusmisell, Buckhannon, West Virginia.  
 Dr. H. D. Solomon, Macon, Georgia.  
 Dr. A. B. Burns, Avon Park, Florida.

## ABSTRACT DEPARTMENT

### SURGERY

*Atlas of Pathological Anatomy*—Supplement to *British Journal of Surgery*, beginning July, 1925, p. 200.

The editors of the *British Journal of Surgery* begin in the July issue a Supplement which is to be an "Atlas of Pathological Anatomy." The plan is to publish monthly plates of specimens from some of the medical museums in England. They hope this work will be of practical value to physicians who are not in the vicinity of medical centers and who are removed by time from their student days when they were in contact with pathology. THE JOURNAL now affords the members of the profession the opportunity to refreshen memories and fix upon their minds pictures of the pathological processes which they encounter clinically. It is helpful also to stimulate in the profession the desire to visit these museums and see at first hand their historic and instructive specimens.

If this first section of the "Atlas" be a true sample of what is to come later, the publication will be without doubt a success. Here is brought to us the subject, "Sarcoma of Long Bones." Nine cases are presented. Full page plates of unusual cleanness are shown. They are of longitudinal sections through the shafts of long bones and the tumors growing upon and through them. There are clinical histories with each plate. Some are accompanied by microscopical sections and X-ray studies.

Of value hardly secondary to the plates is an introduction which summarizes the present knowledge of the nature of the growth of bone sarcomata. The points brought out are well illustrated in the specimens which follow. The "Atlas" when completed will form a valuable

part of any medical library. It will be of practical value to the practitioner of medicine and the surgeon.

E. J.

### MEDICINE

*Pernicious Anemia*—John W. Shuman, M. D., Los Angeles, Calif. *The Journal of Laboratory and Clinical Medicine*, vol. 10, No. 11, August, 1925.

It is his opinion that pernicious anemia as a diagnostic entity should be relegated. He says that heretofore all anemias, regardless of the picture, once the etiology is established, have been called secondary; that anemias presenting a pernicious anemia picture with unknown etiology have been diagnosed pernicious anemia.

Pernicious anemia is described as the result of a defense reaction of the body, as a whole, against toxemia; a long continued fight finally resulting in a state of chronic invalidism, leading to death.

Reviewing recent literature, he deducts these facts:

1. The cause is not understood.
2. Its recognition is not early enough.
3. Its symptomatology is not rationally explained.
4. There is no logical linking of its cause and course.
5. Its treatment is still symptomatic and empirical.

He quotes Hunter as saying that "long standing oral and gastric sepsis" is the cause of pernicious anemia. He concedes sepsis to be a cause, but names other factors; for example, environment, pregnancy, cancer, endocrine disturbance, etc.



The first stage is a toxemia; the second stage is a high grade hemolysis; the third stage, a hemolysis demonstrated by anemia; the fourth stage is a disturbance of the hematopoietic system. He recommends preventive medicine in that a search for the cause should be made and a removal of the toxic agents; second, a correcting of faulty habits of living, and removing contributing factors, if possible, keeping the health index high. The fifth stage he describes as an exhaustion of the hematopoietic system. He states the diagnosis is not made until the fifth stage.

He says there are spinal chord changes in 75 per cent of the cases but usually overlooked because they are not searched for. Weakness of the arms and legs is also an early symptom. Gastrointestinal tract changes are usually found. Visceral changes, such as enlarged spleen, and liver, occur in all cases. The basal metabolism rate is usually increased.

In the treatment he suggests rest; the detection and removal of all focal infection; transfusion; autohemetic therapy; arsenic, diet, fresh air, and sunshine. He concludes that pernicious anemia has a cause, a long-standing toxemia. This toxemia is usually due to bacteria, which the physician should find and remove. Failing this, to treat symptomatically. T. Z. C.

**The Causes and Differential Diagnosis of Headache:** W. Cabell Moore, *Annals of Clinical Medicine*, vol. 4, No. 2, August, 1925.

He says little is known definitely of the actual mechanism connected with the production of the pain in headache. The tissue of the brain is insensitive, but the dura is well supplied with sensory nerves. He classifies the possible causes based upon the location of the primary cause as follows:

1. An intracranial group; diseases arising in the brain itself, diseases of the blood vessels, nerves or meninges of the brain.
2. A cranial group; injuries of the skull, its blood vessels and nerves, the organs of special sense, *e. g.*, eyes, ears, nose and the paranasal sinuses and in the teeth.
3. An extracranial group; causes arising in systemic diseases and in toxemia, bacterial or chemical.

Conditions causing headaches as an independent symptom are focal infection, ocular disease, indigestion, kidney diseases, functional dyspepsia, migraine and organic disease of the brain. A careful and complete history should be taken. The associated factors are:

1. The period of time in which the headaches have been occurring.
  2. The location of the pain.
  3. The character and severity of the pain.
  4. Time of occurrence.
  5. The duration and frequency of the attacks.
  6. Associated signs, symptoms and phenomena.
- Cervical rib as a cause is somewhat uncommon. The diagnosis is not always easily made. Relief is the only proof of a correct diagnosis. Relief may be only temporary. T. Z. C.

### OBSTETRICS

**Version, Its Indications and Contradictions:** Hilliard E. Miller, *Journal of Obstetrics and Gynecology*, August, 1925, Vol. X, No. 2.

Many methods of operative delivery have been developed because labor is becoming more pathologic, practically if not theoretically. None of these has a more definite or more useful place than version. The writer gives Potter of Buffalo credit for his technique and for his service to the profession in bringing version back into prominence, but disagrees with him as to making the operation routine. The fetal mortality is higher and few men could be as dexterous as Potter and hence would not obtain as good results. The author does not believe in version if a spontaneous termination of the labor seems possible.

Cephalic version to change the breech vertex in last month or two of pregnancy is quite often difficult, dangerous, and on the whole unsatisfactory. There is no definite guarantee that the new position will be maintained. If the breech is handled properly, the results are too good to warrant cephalic version, which is not a means of delivery, but a substitution for a condition that may cause even more difficulty than the breech.

He mentions a few general indications for podalic version that are more or less accepted by everyone. In selected cases of placenta previa, where dilation is completed or possible manual, Braxton-Hicks version is the ideal treatment. In certain cases of accidental hemorrhage, version followed by immediate extraction is the operation of choice. In prolapse of cord or an extremity, version followed by extraction is safer and gives better results than other more radical methods advocated for this condition. In transverse and oblique presentations, an elective version is usually called for.

The author also advocates a wider use of version for terminating long and tedious labors, where the presentation is vertex, and where there is some slight disproportion, ineffective pains, or

one of the various malpresentations of the head. Version is preferable to high application of forceps, which procedure the author never uses. If head is in mid-pelvis, and a careful attempt at forceps fails, he immediately resorts to version. Any great amount of disproportion should have called for a Caesarian section earlier.

Certain conditions are essential for the performance of version. Serious disproportion contraindicates this. Cervix should either be completely dilated or easily dilatable. Tetanic contractions of uterus and a high Bandl's Ring also constitute contraindications. He does not agree with the old teaching that the membranes must be intact or just recently ruptured if version is to be attempted. Deep surgical anesthesia is essential to give complete relaxation and to eliminate all reflex and psychic and voluntary muscle activity.

He does a fairly extensive episiotomy in all breech cases, does not consider that haste is at all as essential as has been previously taught. A correct diagnosis of position of baby, slow deliberate and methodical manipulations make for a successful termination, whereas hurried and forceful attempts at extractions are often fatal to baby and injurious to mother. The head is delivered by Mauriceau-Smellie-Veit maneuver.

S. R. N.

#### DERMATOLOGY

Epidermophytosis: A Sequel of Vaccination. W. H. Guy, M. D., and F. M. Jacob, M. D., *Archives of Dermatology and Syphilis*. August, vol. 12, No. 2, p. 233.

Incident to a recent smallpox epidemic and consequent widespread vaccination in Pittsburg, Guy and Jacob observed thirty-five cases presenting unusual dermatologic sequelæ. Epidermophyton Inguinale was found in twenty cases. General examination revealed interdigital epidermophytosis. The report has a good illustration of an active lesion at the site of a vaccination. Treatment used for epidermophytosis was effective. Cultural investigation was made of the vaccine lymph by the department of health of the city of Pittsburg with uniformly negative results.

J. L. K.-S.

#### ROENTGENOLOGY

Lesions of the Diaphragm: Edward L. Jenkinson, M. D. *American Journal of Roentgenology and Radium Therapy*. July, 1925, p. 16.

The author classifies the lesions of the diaphragm into four main classifications, namely:

1. Hernia.
2. Evisceration.
3. Eventration.
4. Thoracic stomach.

As usual the author speaks of the term hernia as meaning the projection of the abdominal viscera, covered by a sac, up into the thoracic cavity. Evisceration includes those cases where there has occurred a rent in the diaphragm through which the abdominal viscera protrude into the thoracic cavity. By eventration he describes the stomach or other abdominal viscera occupying a very high position in the thoracic cavity, but always being below the diaphragm, which is high and relaxed.

Diaphragmatic hernia is much more common on the left side than the right, it may be congenital or acquired, the congenital type predominates. The abdominal organs pass into the thorax early in life. The stomach is the organ most commonly found in the hernia sac, but the colon, omentum, small bowel, spleen, liver, pancreas or kidney may also occupy the sac.

Symptoms may occur early or late. Usually there is a fullness in the chest after eating, sometimes pain, and even cyanosis. All symptoms are greatly exaggerated if the patient lies down, and relieved immediately when the upright position is assumed.

Many pass through life with no symptoms or discomfort and are only found accidentally after careful roentgen examination. It is imperative that all patients be examined in the horizontal position, and also turned while in this position from side to side and observed at many different angles.

Evisceration, often called, traumatic hernia, or hernia spuria, occurs more often in men than women, because men are more subject to trauma. It also occurs more often on the left side, possibly due to the padding protective effect of the liver on the right.

Eventration is rare. The majority of authorities believe it congenital. The diaphragm is thinned out and pushed upward. The lung on the effected side is not compressed. Also more common on the left side. It usually causes no symptoms and is seen best by X-ray. The differential diagnosis between eventration, pneumothorax and paralysis of the phrenic nerve is difficult.

All lesions of the diaphragm are best diagnosed by careful roentgen study, using a barium meal for outlining the gastrointestinal tract and observing the patient in many positions, both vertical and horizontal. The tube tilt table is of great value in searching for hernia and similar conditions.

W. M. McL. S.



### OTO-LARYNGOLOGY

Studies on Pneumonia Following Naso-Pharyngeal Injections of Oil. G. F. Laughlen, M.D. *Amer. Jour. Pathology*, July, 1925.

Using as a basis of study five clinical cases with beginning infections about the nose and throat treated by oil-menthol injections in nose mouth or pharynx and coming to autopsy from a complicating septic pneumonia, the writer conducted a series of experiments on rabbits, using oil injections in the nose and throat and caused death from a septic pneumonia.

He has described the pathological findings at autopsy in both the clinical cases and experimental cases as the same. Particularly interesting note was made of a mono-nuclear cell found in the alveolar exudate and containing unstained droplets of various sizes. The droplets he proves to be oil and the cells containing the droplets he believes to be identical to the phagocyte for "coal dust", the endothelial cell of pneumonic exudate, the epithelioid cell of tubercles, and the "heart failure" cell of passive congestion of the lung.

"The observation is that oil by lowering the resistance of the tissue or by carrying infection from nose and throat may be a factor in the production of pneumonia, by finding its way to the alveoli of lung not only when introduced into the trachea but also at times when administered in sufficient quantities in the nose and throat. And that "Oil when present in the lung is actively phagocyted by endothelial cells which are present in sufficient numbers to dispose of all the oil present and produce consolidation of the lung."

J. L. B.

### PEDIATRICS

Acute Poliomyelitis with a Brief Review of the Recent Detroit Epidemic. John T. Watkins and Earle D. McKenzie. *Annals of Clinical Medicine*, vol. 4, August, 1925.

The identity of the causative agent remains a disputed question, Flexner and his group contending that the etiologic factor is a certain globoid body which they are able to perpetuate while the Rosenow adherents allege the cause to be a pleomorphic streptococcus. The disease follows the line of human travel, is human borne and has its initial growth in the upper reaches of the respiratory tract. Relatively few people are susceptible to the disease. Any new epidemics only exist when a new crop of susceptibles have been raised. The prodromal symptoms are enumerated and should, in the presence of an epidemic, furnish ground for isolation of any patient exhibiting them. The blood picture and cystology are carefully dealt with and emphasized as of

diagnostic importance. Cases showing a spinal fluid cell count of one hundred or less, developed less paralysis than those cases in which the count was higher. A number of cases are reported together with results of treatment employed. Two types of sera were employed (1) that from convalescent patients; (?) serum from immunized horses prepared after the method of Rosenow. The conclusion is that serum therapy does no harm and if administered early may possibly do good. At least the patient should be given the benefit of the doubt. No results are to be expected from serum therapy when employed late. Drugs are of but little value aside from their use as palliatives. Absolute rest is essential till all acute symptoms have subsided. Infected patients should be quarantined for three weeks. The authors found the colored race was practically unaffected as compared to the white race.

J. D. L.

Insulin in the Treatment of Malnourished Infants: Allan Brown, T. G. H. Drake, M. G. Cody and Frederick F. Tisdall. *American Journal of Diseases of Children*, vol. 30, July, 1925.

The reputed good effects of the co-administration of glucose and insulin in malnourished infants prompts the authors to an exhaustive investigation of the subject and a report of a large number of cases with the results secured. Three methods of administration were employed: (1) Intravenous use of glucose and insulin; (2) subcutaneous use of glucose and insulin; (3) administration of insulin before feedings. Most of the infants treated were marantic. These procedures are not without their dangers since the effect of insulin on blood sugar concentration varies tremendously in different infants. Hyperglycemia is of frequent occurrence. In the series reported there was secured a definite increase in weight in fifty per cent of cases, however, other factors existed which lessened the probability that insulin was the cause of the gain. The conclusion is that no positive evidence has been obtained that insulin, administered with carbohydrates to malnourished infants, produces any beneficial effect.

J. D. L.

### THE SOUTHERN MEDICAL ASSOCIATION MEETING

The various committees appointed in connection with the meeting of the Southern Medical Association in Dallas, November 9th, 1925, report very satisfactory progress.

It is especially gratifying to know the hotel committee has already succeeded in having re-



served for guests more than 1,600 rooms in the leading and best hotels of Dallas. This insures you that no matter how great the attendance, each one will be comfortably and suitably provided with proper hotel accommodations. This settles a question which has not concerned the doctors of Dallas who are acquainted with local facilities, but which has been raised by prospective visitors.

For the first time in its history, the Association will have all its activities housed in one building. The new educational building of the First Baptist Church on the corner of St. Paul and San Jacinto streets will be completed long before November and will have a sufficient number of assembly halls for the various section meetings. The large auditorium with its splendid acoustics gives ample room for all general sessions and the basement floor, easily accessible, will give more than enough room for all exhibits, commercial and scientific.

In connection with the Association's meeting in November, clinics in all branches will be conducted in all Dallas' splendid hospitals, which contribute largely to its rank as a medical center of the Southwest. The bed capacity in the larger hospitals alone is in excess of 1,200. Over \$8,000,000 has been invested in the hospital facilities; below is given some data on the different institutions located in the city:

#### BAYLOR HOSPITAL AND MEDICAL SCHOOL

The Baptist Memorial Sanitarium was opened in 1909, being enlarged in 1922 and the name changed to Baylor Hospital. It is the largest sanitarium in the city, having a capacity of 432 beds. One hundred graduate nurses and one hundred and sixty-five training nurses are employed.

The capital invested is in excess of \$3,000,000, the hospital being operated by the Baptist denominations of Texas.

While the main plant of the Baylor University is located at Waco, the schools of dentistry, nursing, medicine and pharmacy are in Dallas. The enrollment is in the neighborhood of 1,000. The medical department will be in session during the S. M. A. meeting, and all its clinics open to visiting physicians.

#### ST. PAUL'S SANITARIUM.

This hospital was established in 1896. The original capacity was 210 beds, but an addition built in 1916 increased the capacity to 300 beds. Two hundred and fifty nurses are employed in

the sanitarium. A nurses' training school is operated by the Daughters of Charity of St. Vincent de Paul, who are also in charge of the management of the main sanitarium. Investments in buildings and grounds are placed at \$1,750,000.

#### DALLAS SANITARIUM.

The first 125-bed unit of this hospital is now under construction and will cost \$500,000. When completed the hospital will contain 500 beds and represent an investment of more than \$1,250,000. It was established and will be operated by the North Texas Methodist Conference.

#### PARKLAND HOSPITAL.

This 250-bed hospital is operated by the City-County Board. It was established in 1896. Ten graduate nurses and seventy-two nurses in training are employed. It is estimated that the capital invested is in the neighborhood of \$1,000,000. Dr. Lane V. Cooke is the superintendent. A nurses' training school is operated in conjunction with the hospital. At the present time plans are being made to enlarge the school to take care of one hundred students.

#### FREEMAN MEMORIAL CLINIC.

This free clinic was first established in the basement of the First Presbyterian church in 1921. In 1924 the clinic was endowed by T. R. Freeman and a beautiful building was erected as a memorial to his wife and son. The clinic is absolutely free and handles an ever-growing number of patients. The building, together with the equipment, is valued at \$100,000.

#### HELLA TEMPLE CHILDREN'S HOSPITAL.

Established in 1923 by Hella Temple for the treatment of crippled children. It contains 50 beds and employs five registered nurses, fourteen attendant nurses and 12 other employees. It is supported jointly by Hella Temple and the Scottish Rite bodies.

The Timberlawn Sanitarium is a 40-bed hospital employing eighteen nurses and treating nervous and mental diseases. It is located on the Orphans' Home road and represents an investment of \$75,000.

#### MEDICAL ARTS BUILDING

The story of Dallas as a medical center would not be complete without some mention of this 19-story skyscraper, completed in 1924 at a cost of \$1,500,000. It was designed for and is occupied by the medical and dental professions. It is of Gothic Cross design, assuring both light

and ventilation to every office. At the time the building was erected it was the tallest monolithic concrete building in the world. About 60,000 patients visit this building every month.

The medical profession of Dallas and of Texas warmly invites the Southern doctor and his wife to visit Dallas on November 9th, 1925.

CURTICE ROSSER, M.D.,  
*For the Publicity Committee.*

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES.

#### PITUITARY EXTRACT OBSTETRICAL—MERRELL.

—A slightly acid aqueous solution containing the water soluble principle or principles of the fresh posterior lobe of the pituitary body of cattle, preserved with 0.5 per cent of chlorbutanol. It is standardized so that 1 cc. has an activity on the isolated uterus of the virgin guinea pig corresponding to not less than 80 per cent nor more than 120 per cent of that produced by 9.005 gm. of standard, defatted, dried, powdered posterior lobe of the pituitary gland of cattle. For a discussion of the actions and use of pituitary solution, see Pituitary Gland (New and Nonofficial Remedies, 1925, p. 260). Pituitary extract obstetrical-Merrell is marketed in ampules containing 0.5 cc. and 1 cc. The Wm. S. Merrell Co., Cincinnati.

#### PITUITARY EXTRACT SURGICAL—MERRELL.—

A slightly acid, aqueous solution containing the water soluble principle or principles of the fresh posterior lobe of the pituitary body of cattle, preserved with 0.5 per cent of chlorbutanol. It is standardized so that 1 cc. has an activity on the isolated uterus of the virgin guinea pig corresponding to not less than 80 per cent nor more than 120 per cent of that produced by 0.01 gm. of standard, defatted, dried, powdered posterior lobe of the pituitary gland of cattle. For a discussion of the actions and uses of pituitary solution, see Pituitary Gland (New and Nonofficial Remedies, 1925, p. 260.) Pituitary solution surgical-Merrell is marketed in ampules containing 1 cc. The Wm. S. Merrell Co., Cincinnati.

SOLARSON.—A 1 per cent solution of ammonium heptenchlorarsonate rendered isotonic by the addition of sodium chloride. Solarson contains from 0.255 to 0.275 gm. of arsenic (As) in 100 cc. Experimental evidence indicates that the arsenic of solarson is readily liberated in the system and is well utilized. It is claimed that

solarson has an advantage over the cacodylates because its arsenic is better utilized, and over the arsenilates in that subcutaneous and intramuscular injections produce less pain and are less liable to produce toxic effects. Solarson is used as a means of obtaining arsenic effects in the treatment of anemia, chlorosis, malaria, neurones and dermatoses. Solarson is supplied in ampules containing 1.2 cc. Winthrop Chemical Co., Inc., New York.

BISMOSOL.—A solution of potassium sodium bismuthotartrate (containing 35 per cent. bismuth), 10 gm.; piperazine, 0.3 gm., in an aqueous solution of glucose sufficient to make 100 cc. Bismosol is proposed as a means of obtaining the systemic effects of bismuth in the treatment of syphilis (Bismuth Compounds, New and Nonofficial Remedies, 1925, p. 73). Bismosol is administered intramuscularly. It is supplied in ampules containing 1 cc. Powers-Weightman-Rosengarten Co., Philadelphia.

CAPROKOL (HEXYLRESORCINOL-S. & D.) 2½ PER CENT SOLUTION IN OLIVE OIL.—A solution of caprokol 2.5 parts in olive oil to make 100 parts. For a discussion of the actions, uses and dosage of caprokol, see Jour. A. M. A., May 2, 1925, p. 1338. Sharp & Dohme, Baltimore.

SAJODIN TABLETS, 1 GRAIN.—Each tablet contains sajodin, 1 grain. For a discussion of the actions, uses and dosage of sajodin, see New and Nonofficial Remedies, 1925, p. 182. Winthrop Chemical Co., New York.

SCARLET FEVER STREPTOCOCCUS ANTITOXIN CONCENTRATED (GLOBULIN)-P. D. & Co.—A scarlet fever streptococcus antitoxin (Jour. A. M. A., May 2, 1925, p. 1338), prepared from the serum of horses treated with subcutaneous injection of toxic filtrates from cultures of scarlet fever streptococci and also with intravenous injections of the streptococci themselves. Each cc. neutralizes from 35,000 to 40,000 skin test doses of scarlet fever toxin. The product is marketed in packages of one syringe containing 2.5 cc. and in packages of one syringe containing 10 cc. Parke, Davis & Co., Detroit. (Jour. A. M. A., Aug. 8, 1925, p. 437).

DIPHTHERIA TOXIN-ANTITOXIN MIXTURE 0.1 L.—A diphtheria toxin-antitoxin mixture (New and Nonofficial Remedies, 1925, p. 333), each cc. containing 0.1 lethal dose of diphtheria toxin neutralized with the required amount of diphtheria antitoxin. Marketed in packages of

three 1 cc. vials: in packages of one 30 cc. vial; in packages of ten vials, each containing three doses. Eli Lilly & Co., Indianapolis.

**TYPHOID MIXED VACCINE, PROPHYLACTIC AND THERAPEUTIC.**—(New and Nonofficial Remedies, 1925, p. 360). This is also marketed in packages of three 1 cc. vials. Eli Lilly & Co., Indianapolis.

**GERMICIDAL TABLETS OF POTASSIO-MERCURIC IODIDE**—P. D. & Co.—Tablets containing potassium mercuric iodide, potassium iodide and sodium bicarbonate, colored blue. (For a discussion of the actions, uses and dosage of potassium mercuric iodide, see New and Nonofficial Remedies, 1925, p. 239). This product is supplied in two forms: germicidal discs of potassio-mercuric iodide No. 2—P. D. & Co., each tablet representing mercuric iodide  $\frac{3}{8}$  grain, potassium iodide  $\frac{3}{8}$  grain and sodium bicarbonate 16 grains, and germicidal discs of potassium mercuric iodide  $1\frac{1}{2}$  grains, potassium iodide  $1\frac{1}{2}$  grains and sodium bicarbonate 45 grains. Parke, Davis & Co., Detroit (Jour. A. M. A., Aug. 15, 1925, p. 517).

**SMALLPOX (VARIOLA) VACCINE (GLYCERINATED).**—New and Nonofficial Remedies, 1925, p. 342). This is also marketed in packages of one tube. E. R. Squibb & Sons, New York.

**TETANUS ANTITOXIN**—LILLY (New and Nonofficial Remedies, 1925, p. 333).—This is also marketed in syringes containing 10,000 units. Eli Lilly & Co., Indianapolis.

**TETANUS ANTITOXIN (PURIFIED)** (New and Nonofficial Remedies, 1925, p. 333).—This is also marketed in packages of 20,000 units. E. R. Squibb & Sons, New York.

**NOVARSENOBENZOL**—BILLON, 0.15 GM. AMPULES.—Each ampule contains 0.15 gm. of novarsenobenzol—Billon (New and Nonofficial Remedies, 1925, p. 50).—Powers-Weightman-Rosengarten Co., Philadelphia.

**NOVARSENOBENZOL**—BILLON, 0.3 GM. AMPULES.—Each ampule contains 0.03 gm. of novarsenobenzol—Billon (New and Nonofficial Remedies, 1925, p. 50). Powers-Weightman-Rosengarten Co., Philadelphia.

**NOVARSENOBENZOL**—BILLON 0.45 GM. AMPULES.—Each ampule contains 0.45 gm. novarsenobenzol—Billon. (New and Nonofficial Remedies, 1925, p. 50). Powers-Weightman-Rosengarten Co., Philadelphia.

**NOVARSENOBENZOL**—BILLON 0.75 GM. AMPULES.—Each ampule contains 0.75 gm. of novarsenobenzol—Billon (New and Nonofficial Remedies, 1925, p. 50). Powers-Weightman-Rosengarten Co., Philadelphia.

**ANTI-ANTHRAX SERUM**—LEDERLE (New and Nonofficial Remedies, 1925, p. 336).—This is also marketed in packages of one 20 cc. vial. Lederle Antitoxin Laboratories, New York.

**TUBERCULIN PIRQUET TEST ("T.O.")**—LEDERLE (New and Nonofficial Remedies, 1925, p. 341).—This is also marketed in packages containing 10 capillary tubes and in packages containing 25 capillary tubes. Lederle Antitoxin Laboratories, New York.

**PASTEUR ANTIRABIC PREVENTIVE TREATMENT (HARRIS MODIFICATION)**—LILLY (New and Nonofficial Remedies, 1925, p. 343).—Supplied in emulsion in syringes ready for use. The package containing the first seven doses is sent from the nearest Lilly depot; the second package containing the last seven doses is sent out from the home office. Eli Lilly & Co., Indianapolis. (Jour. A. M. A., Aug. 22, 1925, p. 584.)

## PROPAGANDA FOR REFORM

McFerrin, The Humorous "Diet Specialist."—Charles B. McFerrin describes himself as a "Food Scientist", "Diet Specialist", "Humorist", has his headquarters in Chicago, although he seems to sojourn largely in the South, giving lectures on "food science" and diet and organizing "courses" among women, each member, it is said, paying \$15.00 for the course. Knowing that physicians are opposed to the exploitation of the sick and the near-sick and possibly fearing that he may expect criticism from the medical profession, Mr. McFerrin anticipates the inevitable, and in places where he conducts his "courses", endeavors to placate by telling what wonderful fellows physicians are. He states to physicians that he always discourages the use of worthless "patent medicines" and advises medical examination by the physician at least twice a year. In addition to lectures that are free and the courses and prescriptions that are charged for, Mr. McFerrin has for sale health bulletins. These are a weird mixture of elementary dietetics, quotations from faddists and advertisements of fads and quackery. A good deal of the advertising in the bulletin is devoted to "Dr." Charles B. McFerrin himself. It contains advertisements of the Porter's Trufoods, Inc., and



the Natur-Way Co., which have occupied the same room in the Chicago office building used by McFerrin as his headquarters. In addition to the sale of courses and individual prescriptions and health bulletins, McFerrin also charges \$2.00 for each letter of information that he writes, which would be cheap enough if the information were trustworthy. Then he has "A Corrective Dietary List" at a cost of \$5.00 and a "Special Diet For the Unborn" at \$10.00. "Dr. McFerrin's Kitchen and Dining Room Chart," printed in two colors, comes at \$2.50. But the real big thing is the "Atonement Dietary Service, Dr. Charles B. McFerrin, Founder." An elaborate, two-page questionnaire comes with the McFerrin Health Bulletin. This the prospective patient is asked to fill out and send with a remittance of \$5.00. (Jour. A. M. A., Aug. 1, 1925, p. 376.)

**THE PARATHYROID HORMONE.**—The recently reported studies make it more than likely that suitably prepared parathyroid extracts contain a substance or substances that will afford complete replacement therapy in the case of the totally parathyroidectomized dog. The methods thus far developed indicate that any extract of fresh ox gland that has been made by a process of weak acid hydrolysis and is sufficiently concentrated contains more or less of the active principle. It has been proposed to use as a provisional unit of potency one one-hundredth of the amount of extract that will produce an average increase of 5 mg. in the content of calcium in the blood serum of the normal dog of approximately 20 kg. of body weight over a period of 15 hours. There should be no haste in a possible human application of the parathyroid hormone. Injection of even very small amounts frequently repeated have invariably proved fatal to animals when the injections were continued. (Jour. A. M. A., Aug. 8, 1925, p. 441.)

**THE NUTROIDS FRAUD.**—Nutroids has been marketed as "a safe obesity cure" by one R. Lincoln Graham. It was claimed (1) that Graham was "an eminent physician, a stomach specialist who has obtained exceptional honors in his profession", (2) that he had discovered "the real cause of fat", (3) that "obesity is brought about by an over-development of alcohol in the digestive tract", and (4) that Graham had discovered the method of preventing the over-development of alcohol by the administration of the product he called Nutroids. The scheme was essentially a mail order fraud. More recently

the nostrum was also sold through drug stores. In due course the postal authorities got around to Graham and his "Nutroids" and secured an agreement that Nutroids would not be sold through the mails. Graham can no longer swindle the public through the mails; if done at all, it must be done through the agency of such retail druggists as are willing to cater to this form of quackery. (Jour. A. M. A., Aug. 15, 1925, p. 522.)

**ANTI-PHYMIN.**—This, modestly described as "the healing gas" and "the greatest curative agent known", is at present prepared by the Phymos Chemical Laboratories of Pensacola, Florida. It is said to be "nonpoisonous to the fullest extent"—whatever that may mean. As is common with quacks, the exploiters of Anti-Phymin have a simple explanation for the complex facts of pathology. All diseases, according to the Anti-Phymin thesis is caused by fermentation. Anti-Phymin, it is claimed, stops the fermentation—and there you are. Anti-Phymin is said to be the discovery of one Cock. In 1916 he was conducting the "Cock Camp Colony and Laboratories" at Kingsland, Texas. This was a "consumption cure" affair in which Anti-Phymin was a part of "the system of treatment." Now, Anti-Phymin is recommended for such a broad field as sore throat, pyorrhea, asthma, "disorders of the stomach", poisoning, "disorders of the kidney and liver", diseases peculiar to women and venereal diseases. It is also claimed to have cured many cases of pulmonary and bone tuberculosis and is recommended for gall-stones, pellagra, appendicitis and diabetes. The A. M. A. Chemical Laboratory examined Anti-Phymin and found it to consist of a dilute solution of sulphurous acid and, necessarily, a small amount of sulphuric acid. This shows that Anti-Phymin belongs to the class of "Liquozone", "Radam's Microbe Killer", "Oxytonic", "Septicide", "Zymatoid" and other nostrums containing as their essential ingredient sulphuric and sulphurous acid. (Jour. A. M. A., Aug. 15, 1925, p. 535.)

**CALCIUM IN TUBERCULOSIS.**—Calcium salts have been administered in the treatment of tuberculosis for various alleged reasons: to remedy calcium deficiency; to lessen inflammatory exudate; to favor calcification of lesions; and to lessen sweating and diarrhea. But calcium is not considered as an essential remedy by critical students of the subject. (Jour. A. M. A., Aug. 15, 1925, p. 539.)

**HINDS HONEY AND ALMOND CREAM.**—According to an analysis reported in 1914, Hind's Honey and Almond Cream is essentially an emulsion containing alcohol, 1.28 per cent; glycerin, 5.79 per cent; partly saponified beeswax, 5.98 per cent; crystallized borax, 1.49 per cent; perfumed with oil of bitter almonds. (Jour. A. M. A., Aug. 15, 1925, p. 539.)

**TUBERCULIN IN TUBERCULOUS ADENITIS.**—Tuberculin seems to be indicated when the disease is strictly localized, and especially in involvement of the cervical lymph gland. Its administration is carried on in the same way as in the tuberculin treatment for other purposes with doses that produce a slight local reaction but fall short of a general one. (Jour. A. M. A., Aug. 15, 1925, p. 539.)

**BENZYL-VIBURNUM COMPOUND NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that Benzyl-Viburnum Compound (Benzyl-Viburnum Laboratory, Washington, D. C.) is marketed in the form of capsules. Each capsule is stated to contain 2 grains of benzyl succinate, viburnum opulus and helonin and powdered ginger root. The name "helonin" has been applied to an extractive preparation derived from false unicorn (*Helonias dioica*) of indefinite composition. Benzyl-Viburnum Compound is proposed for the treatment of dysmenorrhea and "true asthma." Benzyl esters have been found to be without value in asthma. Cramp bark (*viburnum opulus*) and false unicorn (*helonias dioica*) have long been constituents of proprietary "female" remedies, but there is no evidence of their efficiency. The trade package contains recommendations for the use of the preparation in painful menstruation and the advertising suggests that the bottle of the capsules may be carried in the shopping bag. The Council concludes that Benzyl-Viburnum Compound is an indefinite complex and irrational mixture, which is marketed with unwarranted therapeutic claims and in a way to encourage its indiscriminate and harmful use by the public. (Jour. A. M. A., Aug. 22, 1925, p. 628.)

**JOHN D. RICKER, "MAGNETIC MASSEUR."**—An advertisement in an Ann Arbor newspaper notified "chronic sufferers" that John D. Ricker, "Noted Magnetic Masseuse," would be at a local hotel and advised the blind, the deaf and the halt to come and be cured. The health officer of Ann Arbor believes in protecting the fool from his folly and the sick from the quack and, as a re-

sult, he with other local officials were on hand to await the arrival of the magnetic masseur. Ricker did not come, but two of his representatives were arrested, found guilty of practicing medicine without license and ordered to get over the state line in the shortest possible time. (Jour. A. M. A., Aug. 22, 1925, p. 628.)

**SUPSALVES AND MERSALV.**—Supsalvs are arsphenamin suppositories put out by the Anglo-French Drug Co., and Mersalv is stated by the same firm to be a 10 per cent ointment of metallic mercury. In 1920 the Council on Pharmacy and Chemistry reported unfavorably on Supsalvs, because there was no acceptable evidence of the efficiency of arsphenamin administered rectally. Since then the inefficiency of the rectal administration of arsphenamin has been demonstrated by controlled clinical trials. The identity of the ingredients that form the base of Mersalv is not declared by the manufacturer. There is no good evidence to show that Mersalv—or any other proprietary mercurial preparation—is therapeutically superior to the official ointment of mercury. (Jour. A. M. A., Aug. 22, 1925, p. 639.)

**THE NEW PHARMACOPEIA.**—The United States Pharmacopeial Convention met in Washington in May, 1920, and appointed a committee to revise the Pharmacopeia of the United States. The new Pharmacopeia was placed on sale August 15; it becomes official January 1, 1926. The responsibility for the scope of the new Pharmacopeia was placed on the twenty-one members who held the degree of Doctor of Medicine. Consequently, the new book should more nearly represent rational medicine than some of the preceding revisions in which pharmacists and pharmaceutical manufacturers largely controlled the situation. From the standpoint of the physician, the most noteworthy feature of this revision is the fact that but forty new drugs and preparations were added, while 192 have been deleted. The additions are drugs which give promise of therapeutic worth; thirty-one of them are already described in New and Nonofficial Remedies. The omission of such substances as arnica, calcium hypophosphite, cerium oxalate, coriander, grindelia, hops, lactucarium, three lithium salts, matricaria, prickly ash, musk, parsley, pepper, saw palmetto, stillingia, sumbul and taraxicum is a distinct aid to scientific medicine. The retention of sarsaparilla is to be regretted. An effort has been made to simplify the Latin titles: ex-

amples are: the substitution of cinchophenum for acidum phenylcinchoninicum; methenamina for hexamethylenamina; liquor pituitarii for liquor hypophysis. Whereas the present pharmacopeia requires that two drugs and their preparations be standardized biologically, the new book requires that eight must be so standardized. The unit of measurement, the milliliter (abbreviation "Mil"), which is used in the present Pharmacopeia has happily been abandoned again and the familiar cubic centimeter (abbreviated "cc.") restored. (Jour. A. M. A., Aug. 29, 1925, p. 618.)

LONG ISLAND JOURNAL ADOPTS COUNCIL STANDARDS.—Slowly but surely the work of the Council on Pharmacy and Chemistry is receiving recognition. The resolution endorsing the Council's work signed by every member of the house of delegates at the 1916 session is only the official record of the increasing support and encouragement being given by individual members of the profession. Practically every medical journal of standing refuses today to accept advertisements of pharmaceutical preparations that have not met the Council's requirement. This standard has been adopted by all of the official organs of the various state medical associations (with the notable exception of the Illinois Medical Journal). The difficulty of financing a strictly professional journal is no doubt in a great measure responsible for the failure of some publications to close their advertising columns to any but Council accepted pharmaceutical products. That the best of these journals desire to support the Council is shown by a letter from the busi-

ness manager of the Long Island Medical Journal announcing the arrival of the hopefully anticipated time when this publication can afford to solicit advertising only from manufacturers of products that meet the Council's requirements. Henceforth, only such pharmaceutical products as are accepted for inclusion in New and Nonofficial Remedies will be advertised in the Long Island publication. (Jour. A. M. A., Aug. 29, 1925, p. 681.)

ANOTHER MAIL-ORDER REJUVENATING CONCERN DECLARED A FRAUD.—For two or three years past a mail-order concern calling itself the "Melton Laboratories, Manufacturing Chemists" has been defrauding the public from Kansas City, Mo., in the sale of an alleged sex rejuvenator. The "Melton Laboratories" were not laboratories, and the "manufacturing chemists" were neither chemists nor manufacturers. The thing was a crude mail-order swindle operated chiefly by Harold Nelson Stunz. The nostrum put out by the Melton Laboratories was called "Korex." Later, Stunz had two additional drugs added to Korex and put it out under the name "Hiobin" and created a paper organization called the "Hiobin Co." Then Stunz brought out a "Kidney Cure" that he called "Renex." This was sold by the Renex Co., another "paper concern." All three of these nostrums came from the same address; but the public had no means of knowing this, as the addresses were camouflaged to cover this fact. On August 13, 1925, the Melton Laboratories (H. M. Stunz, manager), the Hiobin Co., and the Renex Co., had a fraud order issued against them debarring them from the use of the mails. (Jour. A. M. A., Aug. 29, 1925, p. 694.)



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## RUPTURE OF THE LIVER AND ITS COMPLICATIONS, WITH THE REPORT OF A CASE\*

GEORGE E. W. HARDY, JR., M. D.,  
Tampa

Rupture of the liver, either simple or complicated, is a fairly frequent injury judging from the number of articles concerning it that have been abstracted in the International Survey during the past five years. However, it has not become so frequent as to have become commonplace and the severity of the disease alone warrants our interest in its diagnosis and treatment. According to DaCosta<sup>1</sup> over one-half of the cases die of hemorrhage during the first twenty-four hours. Eighty per cent of the cases will die if not operated upon. The operative mortality has steadily declined since operation was first performed for this lesion about 1885. Edler<sup>2</sup> placed the mortality at 66 per cent in 1887, but more recent authors have estimated the mortality at 40 to 44 per cent. Opinion is unanimous that where the diagnosis is certain, an attempt should be made to save the patient by opening the abdomen and arresting the hemorrhage, and in a suspected case an exploratory operation should be performed.

The symptoms of a laceration of the liver are those of severe intra-abdominal hemorrhage accompanied by hepatic tenderness and respiratory embarrassment. Tenderness and pain may be localized to the hepatic area or not, depending upon the interval of time elapsing between the injury and the time of examination. The abdomen rapidly becomes boardlike and ultimately distended. Usually there is abdominal pain that may radiate to the back. The area of liver dullness is usually increased. Shifting dullness in the flanks aids in the diagnosis of intra-abdominal hemorrhage but does not define the location of the hemorrhage. Another diagnostic aid of similar value is aspiration of the peritoneal cavity as advocated by Charles White<sup>3</sup> several years ago. These tests are of untold value in differentiating between simple shock and shock due to internal hemorrhage. In cases of relatively long

standing, where there may be a slight laceration of the liver with some absorption of bile by the bloodstream, Finisterer has laid stress upon bradycardia, but apart from the fact that other authors have arrived at different conclusions, the relative rarity of bradycardia is against a generalization of this diagnostic sign. The Krauss-Biedl reaction might have some value in these late cases, except the time and skill required for the test.

The treatment of rupture of the liver is immediate laparotomy and the arrest of the hemorrhage. In a diagnosed case, the site of the incision will of course depend upon the lobe of the liver involved. If it is uncertain which lobe is injured, a median incision should be made, although Steiger in 1921<sup>4</sup> pointed out that it is safest to incise where the patient says it hurts most. Lacerations in the superior surface can be reached by the method of Lonnelongue of resecting the eighth, ninth, tenth, and eleventh costal cartilages and drawing the ends of the ribs out. Or the coronary ligament and the right lateral ligament can be cut according to the method of Langenbuch, and the liver can thereby be delivered well out of the abdomen. The hemorrhage can be arrested by the method of Pringle, of grasping the vessels of the porta hepatis between the thumb and forefinger. This allows the assistant to remove the blood and clots from the abdomen and search can be made for the laceration in a dry field. The treatment of the laceration itself will depend upon the size of the laceration, its location in the liver, and the exposure. Small lacerations may be cauterized to arrest bleeding, but this method is unsafe for large lacerations because of the danger of secondary hemorrhage. The method of choice in treating large lacerations is the introduction of interrupted through-and-through sutures of 30-day chromic catgut. A large, round, full-curved needle without a cutting edge should be used for the introduction of these sutures. Two longitudinal reinforcing sutures should be made, using plain No. 2 catgut. Schlatter advocates the stitching of the capsule with fine silk. Where the suturing has apparently produced hemostasis, Wildegans<sup>5</sup> closes the abdomen without drainage and he reports a case of transverse ruptures of the liver, pancreas and stomach treated

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg, May 19-20, 1925.

in this manner with healing by first intention. When the laceration is in the superior surface and there is not sufficient exposure to permit the introduction of the sutures, the wound may be packed with gauze, held against the diaphragm by other gauze packs, or by suturing the liver to the anterior abdominal wall. Chiari,<sup>6</sup> in 1921, in writing of lacerations of the convexity of the liver, advocated arresting hemorrhage by pressing the injured lobe against the vault of the diaphragm and suturing the lobe to the parietal peritoneum of the costal arch. He reported two cases in which this method was tried. One patient recovered. The other patient died as the result of other severe injuries, but the autopsy showed that the hemorrhage had been controlled. Chiari maintained that this method is better than packing, inasmuch as the latter always leads to long continued suppuration.

Besides the treatment of the laceration of the liver per se, in the usual case, shock must be combatted both during and following the operation. Where there has been the loss of a large amount of blood, transfusion of blood is imperative. Autotransfusion is being practised more and more and has given excellent results, although the reaction is slightly more severe than in isotransfusion. It is a relatively easy matter to collect the blood from the abdomen either by a ladle or by aspiration. Little harm is done the corpuscles by either one of these methods. The blood is mixed with the required amount of sodium citrate solution and reinjected. Generally, a second transfusion must be given, as the blood recovered from the abdomen is much less than that lost due to the clotting in the abdomen. Autotransfusion has a limited field, but when indicated is a great aid in a serious emergency. Reaction in autotransfusion is more frequent than in other methods, but it nevertheless seems to be safe. Charles White reports the use of this method in six cases without ill effects. Regarding the time that the patient should be confined to bed following suturing of the liver, Martin Roan<sup>7</sup> states that forty days are required, as owing to the absorption of the stitches there may be additional hemorrhage which must be taken care of by the coagulating power of the blood. The usual time for removal of packs is the ninth day, although cases have been reported where they were removed at an earlier period without harm.

Before discussing the complications of rupture of the liver, a brief review of the anatomy of the

liver might be pardonable. Its close relationship to other organs should be borne in mind. Probably the most important relationship is with the diaphragm, as a very large portion of the surface of the liver is in contact with this membranous muscle. The liver may be said to be slung from the diaphragm by folds of the peritoneum constituting the coronary and right and left triangular ligaments. Of the five surfaces of the liver, four are in contact with the diaphragm. It serves as a partition between the liver and other important organs. The diaphragm separates the base, or right lateral surface, from the right pleural sac and right lung; it separates the anterior surface from the anterior thoracic wall, the superior surface from the right and left lungs and pleural sacs and from the pericardium and heart. It separates the posterior surface from the vertebral column. Other important organs that are in contact with the liver are the stomach, the right kidney and right suprarenal gland, the duodenum, the gall bladder, the esophagus, the hepatic flexure of the colon, and the inferior vena cava, not to mention the hepatic artery, portal vein, and common bile duct. It will thus be seen that any blow or other violence sufficient to injure the liver, can readily injure other vital organs.

Injuries to the liver are accompanied by more numerous complications than most other traumas. These may include the rupture of other abdominal viscera. Not infrequently, the symptoms of the secondary injury are so prominent that they mask even the rupture of the liver. Laceration of the liver may divide bile-ducts and allow bile to escape into the peritoneal cavity and, perhaps, externally. Bile, if sterile, will do little harm to the peritoneum, but if it contains bacteria it will produce diffuse peritonitis. Even sterile bile is corrosive and may cause fibroplastic peritonitis. In a few cases after several days, jaundice and skin itching have been noted. Sugar may appear in the urine. Liver abscesses and subphrenic abscesses may develop from portal stream infection of subcapsular and subphrenic hematoma. The common complications of a severely ruptured liver are fractured ribs, lacerated lung, ruptured spleen, ruptured kidney, and ruptured diaphragm. Doughty<sup>8</sup> reported a case in 1923 in which post-mortem examination revealed a linear tear of the right side of the pericardium through which the heart protruded into the right pleural cavity. A fibrinous exudate was present between the visceral pericardium and



the pleura. In the left side of the diaphragm there was a tear easily admitting the hand. In this opening were the stomach and some of the small intestines, extending up to the pleural cavity. There was a small laceration of the diaphragmatic surface of the liver and some bloody fluid in the peritoneal cavity. These severe cases are not the ones that give trouble from a diagnostic or therapeutic standpoint, because they are rare and there is only one outcome. The cases that first escape attention are often the most difficult to treat and may terminate fatally. An illustration of this type case is that reported by Shingleton Smith<sup>9</sup> some years ago. A woman, aged fifty, had been in good health for the past fifteen years, until ten days before, when she was seized with vomiting and shivering fits. Six months previous to this she had been struck across the right lower ribs by a broom handle, wielded by her husband. When brought to the hospital she had a temperature of 102 degrees. There was severe pain in the right side over the lower ribs, fulness at that area with obliteration of the interspaces, diminished vocal vibration, marked dullness on percussion. Exploration with the needle produced no fluid. A few days later, a trocar inserted into the ninth interspace produced thick chocolate fluid. A rib resection was then performed. Several weeks later a large swelling appeared in the groin. The patient died about one month after admission to the hospital. Autopsy showed the lungs to be normal. There was a large abscess in the liver. Also a psoas abscess. The sinus from the pleural sac extended down to the liver but apparently did not communicate with the liver abscess. There was no connection between the liver and psoas abscesses. Burton Lee<sup>10</sup> reported a case in 1910 of a boy aged thirteen, who was struck by a baseball bat over the right side, low down. There was severe and sudden pain in the region named and the patient was almost breathless for a moment. The patient was weak and thirsty but was able to walk three blocks. When seen at the hospital one and one-half hours later, there was slight rigidity of the abdomen and some tenderness in the upper right quadrant. There was no dullness in either flank. Dullness appeared two hours later. Hemoglobin was 100 per cent, R. B. C. 4,896,000, W. B. C. 30,000. Laparotomy was done and a Y-shaped rupture of the superior surface was found, about three inches long. The hemorrhage was arrested by gauze packing, and the liver was

held up by gauze packs and adhesive straps. Two days later, the hemoglobin was 75 per cent, R. B. C. 3,432,000. On the tenth day the hemoglobin and red count were the same. The W. B. C. were 16,000. Transfusion two days after operation was unsuccessful. Nine days after operation the drains were completely removed. Two weeks after operation, on account of tenderness and fever, an exploratory was performed by Dr. John Erdmann. Nothing could be found in the upper abdomen. One week later there appeared dullness over the right chest posteriorly, low down. Three explorations with the needle were negative. Six weeks after the original operation the right chest was opened by Dr. Lee, with negative results. Two days later Dr. J. A. Hartwell explored with the needle and found pus below the diaphragm, on the left side. The cavity was opened and drained. The cavity did not communicate with the right side. The boy then began to improve. Five weeks after the original operation the hemoglobin was 20 per cent. The interesting features of this case were: 1, the site of rupture, making use of suture or cautery impossible; 2, efficiency of packing for controlling hemorrhage from the liver; 3, long and complicated course of case with final disclosure of left-sided subphrenic abscess.

A case of rupture of the liver presenting many complications came under my care in 1924. The patient, T. V., aged nineteen, a Cuban boy, was admitted to the Gordon Keller Hospital at 8 p.m., January 25, 1924, with the history of having been jammed into a post by his Ford truck about an hour before admission. The patient said he had pain in the abdomen immediately after the accident, but was able to walk to a doctor's office about a block away. He was sent to the hospital on my service. When seen on admission, the boy did not look very sick but complained of pain in the abdomen, not localized to any one spot. The temperature was 99.4, pulse 120 and weak, respirations 24, blood pressure 90/60. The entire abdomen was rigid and the tenderness was general. The patient complained of being very thirsty. There was some dullness in the flanks. A catheter was inserted into the bladder and a small amount of clear urine was obtained. The patient had a severe coryza and laryngitis, but no rales could be heard throughout the chest. The heart sounds were clear. The tentative diagnosis was intra-abdominal hemorrhage from a ruptured viscus. Laparotomy was performed as

soon as the operating-room could be prepared. A high right rectus incision was made. The abdominal cavity was full of free blood and large blood clots. One of these was about the size of a normal liver. The blood and clots were removed from the abdomen and the abdomen was thoroughly explored for the bleeding point. There was some ecchymosis in the transverse mesocolon, but not enough to account for the blood in the abdominal cavity. The inferior margin and anterior surface of the liver were intact, but on inserting the hand over the superior surface of the liver, a large tear about 6 cm. in length was found at the tip of the right triangular ligament and probably extending into the ligament. No tear was felt in the diaphragm. Because of the situation of the laceration and the poor condition of the patient not allowing for further exposure of the liver, no attempt was made to insert sutures, but two large gauze packs were inserted into the tear and the liver held up by two more packs, and the wound was closed. Closure was made with continuous No. 2 plain catgut to the peritoneum, continuous No. 2 chromic catgut to the muscle and fascia, and continuous fine black silk to the skin. Four interrupted silkwormgut sutures were inserted through all tissues except the peritoneum. The patient was infused with normal saline while on the table and after being taken to his bed. On return to the ward from the operating-room, the patient's condition steadily grew worse and therefore he was given 250 c.c. of blood at 4 a.m. As there was no appreciable improvement following this, and he seemed to be sinking, he was given 400 c.c. at 6 a.m. His condition improved greatly following the second transfusion and remained fairly good during the remainder of that day. During the first twenty-four hours the temperature rose as high as 102.4 rectal and the pulse stayed at about 130. The respirations were between 24 and 30 and did not go above 30 at any time during his stay in the hospital. Urinalysis that first day showed a trace of albumen, no casts and many red blood cells.

At 3 a.m. on January 27, the second day, patient became very weak and pulse began to ascend. He was given 300 c.c. of blood at 6 a.m. and responded fairly well. Again that evening his condition became grave and he was given 400 c.c. of blood at 9 p.m. Patient had a severe chill at 10 p.m. and followed by a profuse sweat, and from that time his condition improved greatly.

A blood count made that day showed the red count to be 3,300,000, leucocytes 9800 and hemoglobin 47 per cent. The rectal temperature in the evening rose to 103.6 and the pulse to 140. The condition on the next day remained about the same. On the fourth day the two superficial drains were removed. That day the patient developed a cough and complained of pain at the right base. Examination of the chest by Dr. Grantham revealed dullness on percussion at both bases. Dr. Grantham advised the administration of tincture of digitalis 5i every 4 hours for 6 doses. On this date icterus of the skin and scleræ was first noticed. This increased during the next four days and was most marked on the fifth day after the accident.

On the fifth day the remaining two drains were removed and the condition of the wound was satisfactory. The general condition was good except for the signs in the chest, which remained the same. The following day the left chest seemed to have cleared up, but there was dullness at the right base.

On the seventh day it was noticed that the silkwormgut sutures were pulling out and the upper end of the incision was ragged. The drainage was moderate in amount and consisted of bile-stained serum. The icterus of the skin and scleræ had decreased. The right chest was explored with needle and about 500 c.c. of serum removed. Tapping was resorted to on the next two days and about the same quantity of serum was obtained each time.

On the tenth day the wound had its daily dressing, and since the silkwormgut sutures had almost cut their way through the skin, they were removed, and a tight adhesive dressing was applied to the abdomen. Meanwhile, the patient's cough persisted, although the temperature was gradually descending. On the eleventh day, about 4 a.m., the patient had a severe attack of coughing and soon afterward complained of pain in the incision, but the nurse did not think it necessary to call a physician, as the patient complained frequently anyway. When the wound was dressed at 8 a.m., a loop of bowel was found projecting through the lower end of the incision, where it had become adherent to the gauze dressings. The patient was taken immediately to the operating-room and under nitrous-oxide anesthesia, the bowel was cleansed with ether and replaced in the abdomen. During the first three days after this closure the patient remained in



fairly good condition, but became toxic on the fourth day and vomited occasionally. On the fifth day, February 10th, he was much weaker and vomited large amounts of undigested food. An enterostomy was performed under 1 per cent novocaine and through a left rectus incision. The bowel was opened seven hours after it was brought to the surface, and on opening the bowl fluid shot up in the air about three feet. The patient had instant relief and his condition improved greatly during the next few days. On February 18th fluid again accumulated in the right pleural cavity and thoracentesis recovered 450 c.c. of thin reddish liquid that had a specific gravity of 1020 and showed 150 erythrocytes and 2000 leucocytes per cubic millimeter. Urinalysis at that time showed a 2 plus albumen, a few epithelial and pus cells. The chest was examined by Dr. Blake on February 20th. Dr. Blake thought the pleural effusion was probably due to tuberculosis. Aspiration on the 21st produced 410 c.c. of serum. Aspiration was repeated on the 26th and a large amount of serum was withdrawn. Following the enterostomy the patient began to lose weight rapidly. An attempt was made to give him nourishment by prepared predigested food, administered orally and rectally. On March 1st, the thirty-sixth day after the accident, the hemoglobin was 62 per cent, R. B. C. 3,300,000 and the W. B. C. 16,800. The patient was sent home in an ambulance on March 9th. At that time the right rectus incision was about healed. There had been considerable separation of the skin edges and the scar was wide.

During his stay at home he was under the care of his family physician and every means was taken to build up his strength, but to almost no avail. Nothing could be done in that line until the enterostomy was closed, as this was in the jejunus, judging from the nature and consistency of the discharge. It was decided to attempt this closure in two stages: first a release of the adhesions about the right rectus incision under local anesthesia and as soon afterward as possible the closure of the enterostomy by a lateral anastomosis. Accordingly the patient was returned to the hospital on March 27th. Blood count that day showed the hemoglobin to be 54 per cent, R. B. C. 3,615,000, W. B. C. 9,000. The next day a blood transfusion was commenced, but after inserting 150 c.c., the condition of the patient demanded discontinuance of the treatment. On March 29th the abdomen was opened,

under local anesthesia, through the right rectus scar and the adhesions producing the obstruction were released. These were filmy in nature. Catheters were inserted through the enterostomy to determine the direction and patency of the bowel. During this stay in the hospital several attempts were made to promote closure of the enterostomy by freshening the wound. On April 22nd the patient was brought to the hospital for the third time, and under a short general anesthetic, the enterostomy was closed and a lateral anastomosis was performed. The following afternoon the patient began to complain of pain in the abdomen and the rumblings of the intestines could be heard by anyone in the room. The pulse became weak and rapid toward midnight and the pain increased. At 4 a.m. the next morning the bowels suddenly moved, the patient had instant relief from pain, the pulse dropped from 160 to 120 in five minutes and from that time on patient made uneventful recovery and was sent home on May 1st.

In conclusion we wish to stress the importance of, first, the necessity for early operation in every suspected case; second, the value of autotransfusion; third, the probability of numerous serious complications.

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#### DISCUSSION

*Dr. J. W. Alsobrook, Plant City:*

Dr. Hardy has read us a very valuable paper on the diagnosis and symptomatology of rupture of the liver, but I must say that he had the most grief in the cases that he reported of any man I have ever heard.

It has been my experience—and I think we should speak from experience on rupture of the liver,—and the only experience I have had has been in gunshot wounds. Many of these cases died very quickly and some of them recovered without operation; and some of them recovered with operation, and some died with operation.



I remember a case of a very robust negro man, about twelve years ago, who was shot by his wife with a 38-calibre revolver while he was lying in bed. The bullet entered going through both lobes of the liver. He was brought to my office within thirty minutes and operated within forty to forty-five minutes from the time he was shot. His abdomen being of the very marked muscular type, did not distend but was entirely filled with blood, and there were two bullet holes through the liver, one through the left and one through the right lobe.

I want to digress right here to say that Dr. Hardy recommended the use of a large round needle and No. 2, 25 day chromic suture. I would recommend the use of a small round needle with a plain, soft catgut suture, and you have to have the best, preferably the type known as "un-boilable" suture, which is very much softer, is not so stiff, etc. I use a small round needle of good length and large suture, because of the fact that even with a suture that fills the puncture in the liver you may have a hemorrhage around your suture. If you use a long curved needle and a very large soft catgut suture, it will last quite long enough for healing to take place, according to my experience. In this case I used a No. 4 plain catgut suture with a long curved intestinal needle,—which is a very small needle, requiring a carrier for the suture, as you could not thread the needle. I closed both punctures with No. 4 plain catgut and the hemorrhage was completely controlled. Also, you cannot put very much tension on your suture. As the hemorrhage ceases you want to go very lightly on tying your sutures.

This man was carried back home, and on the tenth day he walked one mile to town. Therefore, it must not require quite forty days for a liver to heal. He got out of bed and walked one mile to town and back. In three weeks he was back at work. That was a gunshot injury and bound to have some devitalization of tissue, and yet that negro's liver healed in the short period of ten days to two weeks. At the end of three weeks he went to work.

I recall another case of gunshot of liver. The diagnosis was made by finding liver tissues inside of the negro's shirt. He was shot in the back, and he got well without any attention.

I had another case of gunshot wound of liver which died within five minutes time. So you can readily realize that a gunshot wound of the liver

which strikes one of the larger vessels, will be just as fatal and just as quickly fatal as a gunshot wound of the heart, or that is my experience with rupture of the liver.

Before closing I would like to stress one point—that of using a long, curved, small, round needle with the largest, softest catgut suture possible.

*Dr. Waas, Jacksonville:*

There are two points in Dr. Hardy's paper that I want to emphasize.

First, Autotransfusion: I recall quite recently a case of automobile injury with rupture of the right lobe of the liver. Operated immediately and gave, I think, either four or five hundred c.c. of the patient's own blood that I removed from the peritoneal cavity. The most marvelous thing about it was the rapidity with which the blood coagulated. You could see it coagulate on the edge of the liver within five minutes following the transfusion.

The second point is the rigidity that comes on and the rapidity with which this rigidity comes on, which rigidity is quite as severe as in the case of perforated duodenal ulcer. I feel that when you have this rigidity you should operate immediately. The idea is to get these cases early. There is no use to wait, for the longer you wait the more hemorrhage and shock you will have.

*Dr. Jos. Halton, Sarasota:*

My experience with rupture of the liver is confined to only one case. This was the case of a man who was in a railroad accident, being crushed between a box car and a hand car, fracturing the right rib with perforation of the liver. This man walked for six blocks, refused help, said that he felt perfectly normal, and suddenly collapsed. He was brought to the hospital where X-ray showed a fracture of the rib. An immediate laparotomy was performed showing perforation of the liver. He died on the operating table. That has been the only experience that I have had with rupture of the liver.

I am going to differ with Dr. Alsobrook about the needle. At Johns Hopkins a number of years ago, they invented a sort of blunt pointed and wide needle, and suturing of the liver can be accomplished with that needle a great deal better than with a small pointed needle. It seems to push away the blood vessels and you do not get so much hemorrhage.

I wish to congratulate Dr. Hardy very much on his paper.

### CONCLUSION

*Dr. George E. W. Hardy, Tampa:*

I want to first thank you all for listening so attentively to the paper, and for the discussions.

Regarding the needles: During my experience I have always used the large needle that Dr. Halton described. All other ruptures or lacerations of the liver, than the one mentioned, which I have seen, were gunshot wounds. I think that is certainly a good point that Dr. Alsobrook brought out about the small needle with gut much larger than the needle, so that you fill up the line of suture afterward perfectly checking the bleeding by the swelling of the catgut.

Regarding the length of time: As you noticed in the paper, a forty-day interval was the quantitative length of time. Of course, in this case we kept the patient in bed forty days, but not from choice.

### REPORT OF A CASE OF IMPERFORATE HYMAN IN A FEMALE RESULTING IN RETENTION OF MENSTRUAL FLUID AND URINE\*

H. E. PALMER, M.D.,  
Tallahassee.

I desire to report a rather unique case that came under my observation several months ago.

Carrie W., colored female, age fifteen, school girl, came to my office for relief for retention of urine. Her mother said "She hadn't made water since befo day," It was then 3 p.m.

She was well developed, and in good physical condition. Complained of more discomfort than pain, in lower abdomen.

While lying on table with abdomen exposed, the abdomen presented the contour and size of a woman in her fifth or sixth month of pregnancy. Palpation revealed fluid. Examination of the vulva revealed an imperforate hymen. Pressure about the perinæum and fouchette gave the sense of resiliency that you get when pressing on a rubber pad.

I catheterized her and drew off about a quart of urine. The resilient feeling about her lower genitalia persisted. I then made a slit in the

hymen, and about a pint of menstrual fluid escaped.

This girl evidently had been menstruating for several months or long enough for the vaginal space to become filled sufficiently to make pressure on her urethra, thereby causing retention of urine.

In connection with this case I recall a statement of Prof. W. T. Howard, Gynæcologist, and Pediatrician of the University of Maryland. He was examining a colored female, age sixteen, and found an unruptured hymen. He stated that in a practice of nearly fifty years this was the fifth case he had found in the colored race. My case above is the fourth that I've seen in an experience of thirty-two years. I give this fact for its historical medical interest.

### DISCUSSION

*Dr. G. R. Holden, Jacksonville:*

Cases like that which Dr. Palmer describes are very interesting, and certainly that point on retention of urine being caused by the pressure of retained menstrual fluid, is in my experience, at any rate, unique.

In this discussion I wish to report a case which came to my attention in 1909, and which is of interest in relation to Dr. Palmer's case. This is the case of a woman who became pregnant and went into labor, the last stage of labor, with a hymen which was 99 per cent imperforate. The patient was one of Dr. J. H. Douglas's, and the history of the case is about as follows:

Dr. Douglas was called one morning to go out and attend this woman in labor. While he knew the family, he had never examined this woman and knew nothing of the case until he got there that morning. As he told me later, when she was apparently in labor, when he came to examine her he was unable to introduce his finger into the vagina. He could feel the child's head within the vaginal outlet, but, as he expressed it, there was a solid wall of tissue between his finger and the head. He did not know what to do as they were on the outskirts of the city, so he sent her to St. Luke's Hospital and I saw her there in consultation. We put the woman on the operating table, exposed the part, and as he said, there was a solid wall of tissue which shut off the vaginal orifice. Behind this was very evidently the child's head, trying its best to go through. The cervix had been fully dilated and the child's head was right in the vaginal outlet and was probably kept from being born for all of three

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg, May 19-20, 1925.

hours by this wall of tissue. We examined for an opening in this imperforate hymen, and of course, there was an opening but it was exceedingly small. After incision through the hymen, the baby was born at once. On examination, we found the hymen at least one-fourth inch thick throughout, but somewhere in that wall there was a slight perforation as she had menstruated. She told us afterward that her menstruations had been dragged out and prolonged, although she had never had any pain. She married about one year before this child was born. Sexual connection, while not perfect, she did not realize that it was not all right. Apparently at the time of connection that wall was pushed upward—there was considerable elasticity to it, and therefore, this outside inverted hymen had acted as a vagina.

I have kept in touch with that woman, and she has had one or two children since then, and has never had any other abnormality. It is, however, of some interest, I think, in connection with Dr. Palmer's case.

*Dr. L. S. Oppenheimer, Tampa:*

I want to report two cases, neither of which, I believe, has ever been put on record.

The first one I saw in the city of Vienna, quite a number of years ago, in which a young woman was brought into the ward for delivery, who had an imperforate hymen. The explanation was, of course, that it was not imperforate or she could not have become pregnant, but it was impossible for them to find the perforation; however, she was pregnant and was delivered after incising the hymen.

The other case was that of a married woman, twenty-two years of age, some twelve years ago in Tampa. She had a vagina, if you wish to call it so, of perhaps one inch in depth. She would have menstrual symptoms every month, but there was no flow of fluid. There was no aperture that I could find anywhere in the so-called vagina until I made it with the knife. In the course of three or four years after that time, she became pregnant, but her vagina was not one inch deep and no menstrual flow had appeared there up to that date. The child is still living and the mother menstruates normally.

*Dr. W. M. Rowlett, Tampa, Fla.:*

This, indeed, is a very interesting paper that Dr. Palmer has given. I was very much interested in Dr. Edwards' embryology, and wish he

had continued it a little further. It seems that it applies in this instance. The uterus and vagina are found by the fusion of the two mullerian ducts, fusion beginning at the lower end and going upward. Now, if there is any interference to these two canals at any point along the entire length, we have these abnormalities that Dr. Palmer spoke of, and the one I mentioned in my paper just preceding,—strictly an accident to the mullerian ducts.

We meet up with many strange conditions of the hymen in the practice of gynecology and obstetrics. Some of these hymens, you will observe, are very elastic, stretch very easily, and may permit sexual coitus without laceration. On the other hand, we might find one that is very rigid and will not permit sexual coitus unless incised. Therefore, as a medical-legal point which you might bear in mind, the finding of an entire hymen is not evidence of virginity.

A question comes to me of whether these various cases of imperforate hymen are purely hymeneal cases. I remember one instance of a patient that had just begun to menstruate and had a vaginal retention; upon close inspection we found that our atresia was due to adhesions of the labia minora instead of an imperforate hymen, and after separating these adhesions we found that there was a hymen beneath. I believe that in many of these instances, a closer observation would demonstrate the fact that many of these so-called imperforate hymens are really vaginal atresia caused from adhesions of the labia minora.

*Dr. C. D. Rollins, Jacksonville:*

In these cases you have retention of the menstrual secretion over a long period of time. I saw one case in a New Orleans clinic, just a couple of weeks ago, of a young girl, about sixteen years old, that had had a retention of twelve to fifteen menstrual periods. This case gave a history of perfect health,—absolutely nothing in the history to indicate any reason for absence of the menstrual flow. The patient was examined and found to have a retention of this large amount of accumulated menstrual fluid manifesting itself by a closed hymen and bulging vulva. The hymen was opened on the table and between one and two quarts of tarry, bloody fluid came from the vagina.

In contrast to this case, I want to mention a case that I had a good many years ago, of vaginal obstruction, where the menstrual flow was re-



tained until the woman was twenty-five years old. The history was one of perfect health. This was not a typical case of retention but was a case of atresia similar to the case mentioned by Dr. Rowlett. There was an obstruction of the vaginal opening one-half inch internal to vulva opening. She had never menstruated in her life and was a perfectly healthy woman.

She was married at the age of twenty-two and the case came to me on account of the sterile marriage of two or three years duration. When I examined her, the obstructed vagina was discovered and attributed to an atresia. The blocking possibly might have been due to the hymen having been pushed back by persistent copulation which had never, however, been reported as difficult. It was entirely due to the fact that she had a sterile marriage that she sought medical advice. In this case I made a crucial incision through this vaginal obstruction and she expelled just a few ounces of dark, thick, tarry menstrual fluid. She had passed over possibly one hundred and fifty menstrual periods and only had at this time just a few ounces of menstrual fluid, probably from one or two of the last periods. This seems to indicate that the vaginal mucosa had assumed the power of absorption or redistribution of this menstrual fluid.

The case of the young girl who had passed over fifteen menstrual periods and had more than a quart of retained menstrual fluid, illustrates that the vaginal mucosa had not acquired the function of reabsorption.

It may be mentioned in the case of the married woman that she became pregnant immediately after operation, and I delivered her at term.

*Dr. L. A. Peck, West Palm Beach:*

This is a case that I recite to bring out the features that we might meet, and to show that we sometimes find no hymen at all. This is a very unusual case, that of a negress about nineteen years of age. She was well developed, but her facial expression showed a little bit of timidity, or rather an exaggerated feminine appearance. We were unable to manipulate the cervix, so carried her to the hospital. I had one of the surgeons to assist me, and we started in. We worked up for three and one-half inches and found no trace of a vaginal canal. There was no indication of a vaginal orifice. We then made an incision into the abdomen to verify these conditions. We found that both ovaries were good, of normal size, and that they were ovulating. The

fallopian tubes were well developed, and both the round and broad ligaments were present. On hunting for the uterus we found it to be only three-fourths of an inch in length and less than one-half inch in width—all that was to be detected. We tried to bring this down and hold it until the tract to the vaginal canal was made, and did this with success. Now, both the labia majora and the labia minora were both fairly well developed, and the hair around the vulva was also normal. The mammary glands were both normal in size.

This individual was kept in the hospital for six weeks, during which time she had grown one and a half inches, and the mucous membrane had filled in. When it came my time for an annual vacation, which I spent in New Orleans, last year, I asked the interne to continue this vaginal pack. When I returned in six weeks the whole thing had pushed back, and we were never able to establish, or rather bring down, this infantile uterus. Yet, all the rest of the generative tract, including the mammary glands, were complete.

The attempted vaginal opening was a success and maintained for six weeks, but after that the upper two-thirds closed. I have not attempted to do any further reconstruction of the adhesions in the vagina.

## CONCLUSION

*Dr. H. E. Palmer, Tallahassee:*

I really cannot account for the disappearance of the fluid in the case referred to by the gentleman who discussed my paper. As a matter of fact I cannot explain why the fluid, or rather, how it could be absorbed if it was ever there, because the vagina has no absorption powers. It must have been just a case where the woman had not begun to menstruate. We know as a matter of fact that there are perfectly normal women who do not menstruate before twenty or twenty-five years of age. I appreciate the interesting discussion that my paper called forth.

## A LIMITED SURVEY OF THE THERAPEUTIC ACTION OF THE SUN\*

DR. W. W. AND O. B. McKIBBEN,  
Miami, Florida.

What is the action of the sun on the organism? This is one of the most interesting questions asked of modern science. In the first place, there is a double action of light on the body, its direct

\*Read before the Dade County Medical Society.

and indirect action. The work of Wiesener has proven that the infra red rays and more especially those near the red are bactericidal and by means of these long wave lengths they penetrate the body tissues, coming in contact with deep-seated lesions.

We all know that the violet and ultra violet rays held at a depth of one millimeter in the skin are absorbed by the superficial sanguine surfaces formed by a network of capillaries, dilated by the sun. It is to the action of these rays that we may attribute the phenomena of erythema and pigmentation.

Pigmentation gives protection against the irritation provoked by the ultra violet rays and it also regulates the action of the thermic part of the solar system. The biological value of pigment is recognized increasingly by scientists. It is probable that pigment receives supplies and increases the activity of the elements essential to metabolism.

Bloch has demonstrated a substance very much like adrenalin; submitted to the action of an enzyme of the epidermis, it produces the formation of epidermic pigments, light strongly accentuating this formation. On the other hand these ferments of the epidermis seem to depend upon the quality of vitamines contained in the food. This has been proven recently by the experiments on rachitic and underfed children in Vienna. The action of radiation produces a very strong retention of the lime phosphate in the body, which has reached 400% as a maximum.

We must remember that the action of sunlight on the hematopoietic system is followed by an increase in hemoglobin. This was proven by Naegeli, and Behring demonstrated an increased activity of respiration in the red globules submitted to the sun. Schlapfer has given the proof of photo activity of a photographic plate by means of its exposure to previously insulated blood. The last experiences of Sonne in Copenhagen have proved that under the action of radiation the temperature of the blood at a depth of more than one-third of an inch under the skin augments to about five degrees C.

From all these experiments must be drawn the conclusion that the light absorbed by the blood changes it into a receptacle of radiant energy. Transferred into the whole organism this energy hastens the ultra cellular forces of oxidation and reduction, thus modifying the whole metabolism.

Consequently, in this way, the organism ex-

posed to the action of the sun is made better fit for the fight against infection, particularly against tuberculosis.

Chief among the general effects of the sunlight upon the body is the action of the sun's rays upon the skin. The skin is not only the natural clothing of the body but it provides for us a compact web of capillary vessels. These vessels by their contraction and dilatation constitute a kind of "peripheric heart," a regulator of the circulation of the blood. The skin is also an expansion of the nervous system; this closely woven net of sensory and sensitive nerves may be compared to a keyboard, the lightest touch upon which provokes resonances through the whole organism. The skin is not only an organ of protection, circulation and enervation, but also one of respiration and nutrition, since it gives off carbonic acid and water vapor, and absorbs oxygen. In conclusion the skin is an essential organ of elimination, and of greatest aid to the kidneys. It may be considered of more importance even than the kidney, for one whole kidney may be removed and life continue indefinitely, while if one-third of the cutaneous surface is destroyed, death ensues.

Air and light are as necessary to the skin as water to the scales of a fish; though the skin may be weakened by generations of the wearing of clothing, under the influence of air and sunlight it recovers the power to accomplish its vital functions. The very gradual formation of pigmentation gives the body proportionately increased resistance to cold and heat, and lessens the danger to any infection.

Air and sunlight should always be taken gradually, almost drop by drop, so to speak, when the thorax is exposed. The sun bath enlarges the capillaries and determines an afflux of blood toward the skin. This is a better regulator for the circulation than the best massage and the entire body finds again its natural harmony. The tonic power of the sun also manifests itself on the thoracic and abdominal organs; under its influence internal secretions accentuate, hemoglobin increases, digestive functions become regular, and strength generally is renewed. The sun acts not only on the physical side but on the mental as well. This is of great importance when we realize how much the mind reacts on the physical side.

One of the most important problems in heliotherapy is the dosage. On the knowledge or the



lack of knowledge of posology depends the results we may expect from sun cure, and no method demands such strict individualization as heliotherapy.

A very current mistake consists in thinking that the sun bath is more efficacious if prolonged or taken when the sun is hottest. Nature herself seems to warn us against this mistake. Only the lower less sensitive parts should be exposed. The further progress in isolation will be based upon observations of the measure in which the patient bears the treatment. Sun baths should never be taken during the heat of noon, especially at sea level where the ambient atmosphere tends to weaken the patient, producing congestion and annihilating the good effects of the sun's rays. The early hours of the morning are best.

To be most beneficial, the sun bath should create a sensation of profound wellbeing. The after effects should be invigorating. Needless to say, a patient with a high temperature should not be exposed to the sun.

Expensive palatial sanatoria are not necessary. Some simple place with plenty of court space, or any house with the addition of a large balcony would serve as well.

As prophylactic treatment sun cures are invaluable. Sun is, indeed, the sovereign remedy that a farsighted Nature has placed within the reach of all. It behooves us to make the most of it. The human body, everlastingly threatened by evil forces, must be constantly and effectually armed against them.

The treatment of diseases by sunlight is the newest of old things. Hypocrates, founder of medicine, practiced it systematically. The first clinic for heliotherapy of surgical tuberculosis was opened by Dr. A. Rollier at Leysin in 1903, and at last it would appear that his methods are to be followed throughout the world. Already France and Italy have practiced the sun cure and it is now being carried into Sunny Spain. There are many heliotherapeutic institutions on the Riviera, from San Remo to Cannes; the city of Lyons sends its sick children to the Villa Santa Maria at Cannes and the Italians have established a splendid institute at San Remo.

In our own country there is a large following at Perrysburg, N. Y., near Buffalo, and numerous smaller institutions throughout the country. Dr. Amstead has contributed papers on the sun cure of non-tuberculous diseases. We must not associate the sun cure, exclusively, with tuberculosis nor solely with the antiseptic power of sun-

light. Recent work at Columbia University and Johns Hopkins Hospital has shown that sun light has potent influences upon nutrition, and is capable of preventing and curing rickets in a fashion hitherto unsuspected. Amstead refers to rickets, but at the time he was not well acquainted with this new American work.

Statistics from Madrid, Munich and Mexico City, teach us that tuberculosis may occur even at high altitudes. Dr. Rollier insists, in his most recent publication, upon the superior value of the early morning sun.

It is not necessarily light and heat which do the most good. In Canada it is light and cold which contributes to the superb Canadian physique and vitality. It has been only within a comparatively few years that we have known how to use the sun rays for therapeutic purposes. Heliotherapy is better carried on in high altitudes because it is usually above the clouds and smoke.

Ultra violet rays can be produced by artificial means. In Funsen's early work he used an ordinary arc light, which is very powerful in ultra violet rays, particularly if iron electrodes are used instead of carbon. Later on, lamps were constructed which deliver a light rich in ultra violet rays through a quartz tube or window. Estimations seem to show that more ultra violet rays per minute are produced by this means than would be obtained by exposure to direct sunlight at high altitudes.

The work which has been done on rickets with the quartz light therapy, demonstrates that marked changes in metabolism take place.

Internal and external tuberculosis are not only local ailments but must be regarded as manifestations of a general infection, which produces local symptoms and makes its appearance in local seats of disease. The therapy employed must give a general effect and completely restore the patient's normal constitutional condition and this must be coupled with a radical local treatment which will not hinder but promote the necessary rebuilding of the whole system.

Sun cure may be applied wherever the sun shines at sea level or in the mountains; anywhere where there are no dust particles and smoke to hinder the treatment, and where the treatment may be continued all the year around. This uninterrupted cure keeps the maintenance of the body at its maximum vitality.

In Pott's disease, instead of having patients in heavy plastered jackets which determine a very considerable atrophy not only of the skin and



muscle, but of the bone, they now have a simple arrangement of webbed straps which give sufficient immobilization while permitting free access of air and sun to the injured places. As soon as Roentgen examination shows the beginning of calcification of the vertebral block, the patient is placed in a ventral position. The thorax is supported on a triangular cushion on which the patient may lean his elbows. To this physiological position we attribute a very great importance. This same position was advocated about 100 years ago by two English doctors, Banting and Baumfeld, and it had long been abandoned; now it has again been given the consideration it deserves. This position augments the lordosis and tends to correct the pathological curvature. It protects the whole dorsal region and so develops and strengthens the muscles and ligaments.

Heliotherapy gives the most favorable results in cases of tubercular peritonitis. This requires most careful supervision, especially if it is accompanied by pulmonary and pleural complications.

Heliotherapy is the preeminently successful treatment for cervical adenitis, which may be cured without leaving any scars by one of the three processes: "melting" generally followed by aspiration, spontaneous resorption, or sclerosis. The first two mentioned occur more frequently than the third. The exclusive use of heliotherapy has the advantage of never giving rise to such accidents as radio-dermotitis.

Arthritis is one of the greatest benefited of all diseases. A man who had spent fifteen years traveling from one cure to another, from one part of the country to another, seeing physicians and taking baths, finally arrived at Miami Beach in a wheel chair and in constant pain. His hands were knotted and he used them with great difficulty. He spent three hours every morning lying on the sand with the sun pouring gently into his skin. A thin bathing suit and a head mask were his only covering. His condition was benefited steadily and surely, and at present writing, he swims, drives a motor car and a speed boat, walks without the help of a cane, and even dances occasionally.

Still's disease and other forms of arthritis do well here in Florida. A boy of fourteen, thin, sad-eyed, and drooping, spent six years in bed and wheel chair. There were long nights of excruciating pain and the days were hardly more endurable. Today after one winter and summer exposed to sunlight he has gained twenty-five

pounds in weight; his cheeks are ruddy brown and his eyes bright. On account of bony ankylosis in his left hip joint, he still uses crutches, but the orthopedist thinks this is correctible. With the help of an inflated inner tube, he swims. When he first arrived in Miami he made two suicidal attempts, each time after a night of frightful suffering. Now this sunny little philosopher fairly radiates health and happiness.

An orthopedic hospital is being constructed on the beach at Miami by the Shriners, to which children will be sent from the Southern States.

Anemias, both primary and secondary, convalesce rapidly in this climate. It goes without saying that the etiological factors in the above disease should be removed where possible.

Pernicious anemia is a disease of unknown cause. A physician friend tells us of a case arriving from the West, unable to sit up in bed, even for a few minutes. Laboratory work here corroborated that in the West. In order to expose the spleen, a two-pieced bathing suit was donned and the patient was carried to the beach daily. Two months later the man walked into the doctor's office saying: "The sun has almost cured me, I am going home to sell my business and come back here to live." Unfortunately, he postponed selling his store and died there eighteen months later of pernicious anemia.

The climate at Miami Beach has as much power to cure as the sun. No dust particles nor smoke hinder the cure, for the beach is a long narrow strip of sand separated from Miami proper by a three-mile viaduct and causeway.

Thirty-four per cent of our children in the United States are more than seven per cent underweight. The writer has utilized heliotherapy in South Florida in his school nutrition classes, transporting these children to the beach, putting them into bathing suits, weighing them, making physicals each week on all not gaining properly, giving swimming lessons in the ocean or the swimming pools, and dairy food luncheons after the rub-downs. As many as a hundred and fifty children have been cared for in a single morning. Some of these were so-called "fatigue cases" with possible evidence of tuberculosis. These cases use up more calories than they store. They flit from one object to another as do the restless butterflies.

Finally, heliotherapy gives the most satisfactory results in all cases of lupus.

Results of sun-cure can only be considered val-

uable if they are lasting. Those who have suffered should henceforth live, as nearly as possible, under conditions nearly approaching those which determined the cure. To avoid relapse, a patient should neither take up an unhealthy occupation, nor re-enter an unsanitary lodging, but rather choose a vocation that promises reasonably healthy conditions of life. Market gardening would be a beneficial work for an ex-patient, in a good climate, of course.

Sun and air should be given a larger place in our daily lives. Defective housing has played a large part in the illness of children. There is an old saying: "Where the sun enters, the doctor does not go," and contains a rule of life that should prove invaluable in its application.

### MAGNESIUM SULPHATE IN ECLAMPSIA\*

A. D. STOLLENWERCK, M.D.,  
Jacksonville

In the treatment of eclampsia, it is universally agreed, that two indications present themselves: 1, to combat the effect of the toxins upon the central nervous system; 2, to eliminate these toxins.

Since the employment of magnesium sulphate to control the convulsions of tetanus, much work has been developed in its use in the convulsions of eclampsia, and the explanations of its action, in meeting the two above indications, seem to be found in the following reports:

Blake claims for it, in tetanus, "a marked effect in restraining convulsions and relieving pain, thereby conserving strength, and preventing excessive metabolism and heat production; that spasm of the muscles of mastication and deglutition is at least lessened; that its action is continued for a considerable period (29 to 34 hours), without depressing action on the heart muscle, and finally, that repeated injections produce no harmful effects, except the inhibition of the bladder, and subsequent need for catheterization."

Peck and Meltzer report on its use for the production of anæsthesia and conclude that "the employment of intravenous injections of magnesium sulphate as an anæsthetic may prove to be, indeed, a practicable and advantageous method, because, in the first place, it may cause simultaneously a moderate relaxation of the

muscular mechanism, and secondly, because the untoward effects can be readily reversed by the administration of a solution of calcium chloride."

Weston and Howard report on their use of this salt in excited stages that they found "In 82.7 per cent of the cases, the sedative action was prompt, the patient becoming quiet after 15 or 30 minutes, and sleeping from 5 to 7 hours. In a few instances, the patient became quiet but did not sleep, the effect persisted from 5 to 10 hours."

The above seems to meet the first indication—the effect of the toxins upon the central nervous system. As to the second indication, the elimination of the toxins, magnesium sulphate seems to act in the blood-stream like it does in the intestinal tract, viz., to extract fluid from the tissues, thus reducing the edema. In reducing the edema of the brain, the coma clears up more rapidly. This increase in the watery elements of the blood increases the kidney output, and thus eliminates the toxins.

We regret that we have only one case treated by this method to report, and naturally, you may feel that it is not at all conclusive, but it occurred immediately after the appearance of a report of seventeen cases by Lazard, and finding our result so strikingly like his, we do not feel that ours was entirely accidental.

The patient—white, married, eighteen years of age—was brought into the hospital on the night of March 8th, 1925, in an unconscious condition, with a history of having had four convulsions. The husband said that early that morning the patient complained of a severe headache, which became worse, and she went to bed in a stupor. This being the only time the patient complained of any illness during her pregnancy. About noon a midwife was called, who gave her a dose of salts, and advised that they send for a doctor. About 4 p.m. she had a convulsion which lasted four or five minutes. At 6:30 she had another, and on her journey to the hospital she had a third. About twenty minutes after her admission she had another convulsion which lasted five minutes. There was edema of the face and eyelids, and lower extremities. The blood-pressure was 160/100, and a self-evident diagnosis of eclampsia was made.

At 9:40 p.m. she was given one-quarter morphine sulphate, by hypodermic, and at 10 o'clock 20 c.c. of a 10 per cent solution of magnesium sulphate was ordered, intravenously, but through a misunderstanding of the order, she received a 20 per cent solution instead, so the mag. sulph.

\*Read before the Duval County Hospital Staff Meeting, August 18th, 1925.



was not repeated. At 10:30, 500 c.c. of normal salt solution was given under her skin, and repeated at 4 a.m. On the morning following admission, the blood pressure had fallen to 145/100, she was passing a good amount of urine involuntarily, and the mental condition was that of semi-stupor. She could be aroused easily, would answer questions, and then return to a light sleep. At 2 p.m. consciousness returned and the patient asked for the bedpan. There were no further convulsions. She was put upon a milk diet, with water freely. We purposely omitted any of the usual treatments, as we did not want to disturb her with stomach washings, colonic irrigations, etc., and further wanted to test the efficiency of the magnesium sulphate. On March 12th she again complained of headache. Her blood pressure had risen to 160/100. She was given 10 c.c. of 10 per cent mag. sulph. intramuscularly. The following day she went into labor, and later the blood pressure was 140/100. Her labor was normal, her infant normal, and her puerperium uneventful.

The urine report, from a specimen taken the morning after admission, showed 3 plus albumen, and hyaline casts. On the 11th—two days later—showed 1 plus albumen, and no casts in ten fields. On the 18th, there was a faint trace of albumen. This, being taken, 5 days postpartal.

The patient was advised that she should remain longer for treatment and it was our intention to transfer her to the medical department, but she insisted upon going home, and signed her release on March 26th.

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## OBSERVATIONS ON A VISIT TO SOME EUROPEAN MEDICAL CENTERS\*

EDWARD JELKS, M.D.,  
Jacksonville, Florida.

In giving an account of my recent visit to some European medical centers, I wish to state that what I shall say is based altogether on my own observations. Some one else, no doubt, would have gathered quite different ideas. In London I visited St. Bartholomew, Guy's, and Westminster Hospitals; in Leeds, The Leeds General Infirmary; in Paris, Hospital de-la-Salpêtrière; in Strasbourg, The University Hospital.

The fact that impressed me most about these

institutions was the tremendous degree to which they are influenced, I might almost say limited, by precedent and the past. The countries themselves seem to have been born, to have grown to their present condition, rather than to have been created or planned. Many things of everyday life are reminders of what has gone before. Even the names of streets often tell fascinating stories. Wood street, Bread street, Milk street, tell us that in times long gone, the Londoners on certain days of the week went to these streets to purchase the household articles of their simple life. The best markets to get milk were on Milk street; bread on Bread street and so forth and so on. In spite of a fire which completely destroyed this section of the city, almost three centuries ago, we still enjoy the fascination of walking these streets which continue to bear their original names. In Paris the names of the old gates of the mediæval city still denote where entered for hundreds of years kings, conquerors, serfs, artists, mobs and all manner of people from the far countries of the earth.

The hospitals also possess this charm of age. St. Bartholomew or Barts in London, dates back to the middle ages. It was founded in 1123 as part of an Augustian Priory. Rahere, its founder, lies in the beautiful early English chapel which he built as the center of his institution; an institution which has stood for the best in religion, education, and medicine during eight hundred years. You may be sure that the British medical student digests its eight centuries of medical history. A third-year student took me from the old Priory church, holding the founder's remains, to the modern buildings of the up-to-date, out-patient department. This young man told me with pride, that at Barts, Owen and Abernathy had taught. It was here Harvey made his discovery of the circulation of the blood. These men are proud of their hospitals, and well they may be, since most of them can boast of the ripe old age of at least a hundred years. What can be more inspiring to a visitor and student than knowing Hospital de-la-Salpêtrière? It was built by Louis XIII in the 17th century for an arsenal, but was soon converted into a medical home for old women, chiefly for those with mental diseases. It was here during the past century that Charcot, of joint fame, took his internship; later he was appointed chief of the clinic and for many years filled the chair of neurology which had been created for him. From Charcot and his associates we have received some of our

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\*Read before the Riverside Hospital Staff, August 26, 1925.



earliest and best information concerning diseases of joints and the nervous system. Today one sees in the wards, in the corridors and in the open courts hundreds of old women with almost every conceivable type of deforming arthritis and paralysis. There is now a modern surgical hospital connected with this old institution.

We must not forget the medical museums. How pleasantly I remember the morning I spent in the Hunterian Museum of the Royal College of Surgeons. Our war of independence had hardly closed when John Hunter, who died in 1793, had begun this museum. It still treasures his original specimens, labeled in his own handwriting. In the central gallery is an impressive statue of this great founder. Five large rooms with cabinets along all the wall space and galleries above are filled with specimens. There are skulls from almost every living tribe or race and some of pre-historic man. Anatomical dissections minutely labeled are preserved. I must recall that never before had I seen such wonderful specimens. Then there are similar pathological displays. There are many models reconstructed from microscopical observations. One impressive work of this nature is series of models of cell nuclei showing chromosomes undergoing division. Illustrative of the magnitude of the museum is the fact that in 1871 there were catalogued 1005 urinary calculi, most of which have been analyzed chemically. How many there are today I did not find out. Happily this museum is more than a mere medical curiosity. Here I saw many groups of students, accompanied by their instructors in some instances, studying at first hand the collections of more than one hundred years of British medical and surgical history.

Now what influence do we expect such a medical history and environment to have upon the profession of England and France? These countries have developed certain ideas and methods which they find difficult to change. Apparently they like to repeat what they have done before. They prefer not to undertake the new and untried. The old is good, they say. Wherefore, precedence and custom have circumscribed their medical institutions.

The younger doctor must adapt himself to the old ways. He must come from a certain school and pass through a prescribed training and experience in order to be recognized. The younger men are held back, especially those of other countries. A physician in Paris told me that

this is one of the greatest hinderances to medical progress in France. A notable exception to this custom occurred last year when one of the oldest hospitals in London appointed on its staff a surgeon from a British colony. I was told that this hospital had appointed an outsider very few times in its hundreds of years of existence. To arrive, a man must follow the pathway along which he is directed. One would think this must be a hinderance to the originality of the individual and to the best interest of the institution.

But there is a much brighter side to this practice of holding fast to the old. Lessons of great value have been learned from years of experience. Time has tried and proven them. Therefore, these are adhered to while the profession is very slow to accept the untried or unproved. This must result in the avoiding of many mistakes that are made by those who accept too quickly. They give proper importance to the fundamentals of medicine. They stress the training of the senses to detect and the development of the mind to interpret correctly. They do not lay so much stress in diagnosis as we do upon laboratory findings. Illustrative of their reliance upon the clinical history and examination is the reply of a British neurological surgeon to my inquiry as to whether they used ventriculorrhaphy in intracranial diagnosis. In a half serious manner he replied, "No, we are clinicians over here." At least clinicians are what they aspire to be. So far as I could observe they make as high percentage of correct pre-operative diagnosis as we do.

I have asked myself many times, "What is to be the future progress of medicine in these countries?" In a spirit of humility for our country I express the opinion that they look for America to take the lead in medical progress. They say, you have laboratories for research, funds for needed equipment, endowment which enable men to devote their lives to investigations and you have a nation of peace. With pride in our leaders, I can see they already recognize that America has established a worthy position in the medical world. Two surgeons said to me when operating upon goiters, "I hesitate to do this operation in the presence of one who comes from the country of Chile."

Not only the profession but the laity will be awakened to our medical methods. In the June issue of the *English Review*, is an article entitled "Medical Methods in America and England." In this the author presents, through a layman's

periodical the points wherein he considers America more advanced. Doubtless these old countries will not accept our methods quickly, but I think they will choose and prove their value; then add them to their already superior schools of medicine and surgery. We will continue to learn from Europe new ideas in medicine; but I think most of all we should learn from her to cherish the history of our institutions, the memory of our leaders in medicine. We should stress more and more those fundamentals which have been proven by time and experience. Let us learn from our friend across the sea that we have no other aids in medicine so valuable as the senses and reason.

### TYPHOID FEVER\*

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The clinical history of an attack of typhoid fever is divided into weekly periods. While these are not absolutely accurate in time, it is a convenient division and one which roughly corresponds with the pathological process in Peyer's patches. In the average uncomplicated case of moderate severity, the first week is the period of the increasing severity of all symptoms, the second and third weeks constitute the period of the height of the disease, the fourth week is a period of decline of all symptoms and the fifth week marks the beginning of convalescence.

The exact time of the incubation period is still a matter of some speculation; the average time appears to be from 10 to 14 days, but it may be as early as two days and the invasion of the intestinal wall may be indefinitely delayed as is seen in the case of apparently healthy carriers. In laboratory infections, both experimental and accidental, Jennings and Morse report an average time of 14 days, at the same time mentioning cases which developed in four, five and six days. Usually no symptoms mark this period, the onset being so insidious as not to attract the patient's attention, but subsequently a history of lassitude, loss of appetite and some headache or other pain can frequently be obtained. The prodromes are followed by the onset of fever and a gradual increase of all symptoms so that the patient takes to his bed. This event is commonly considered the first day of the invasion.

The picture then develops about as follows: There is chilliness followed by fever, occasion-

ally a real chill; great fatigue, dizziness, loss of appetite, abdominal pain and discomfort, occasionally vomiting, usually constipation, maybe diarrhoea, but this is usually induced by the use of some laxative. There is headache; this is severe and does not yield to treatment; nose bleed is fairly common on the second or third day. The temperature shows an evening rise with morning remissions gaining a degree or thereabouts each day over the day before so that by the end of the week it reaches 103 or 104. The pulse is soft and full and in comparison to the temperature and the evident severity of the attack the rate is low. There is restlessness, the skin is hot and dry, there are occasional sweats. The thirst and anorexia increase, the abdomen may be somewhat distended, there may be some pain or a feeling of discomfort in the lower right quadrant, palpation discovers movement of gas in the colon. If there has been constipation it persists or there may be one or two loose stools daily. The tongue is moist and coated, the breath foetid, there may be a slight dry cough or even some dyspnoea. All symptoms increase daily in severity. This occupies a space of about seven days, the first week of the disease.

Usually between the seventh and twelfth day the rose spots appear on the skin of the abdomen and chest. The rash is variable but usually consists of only a few of the spots at a time, occurring in crops; there may be so few in any one crop as to escape notice entirely. The temperature remains high, the morning remissions becoming less; the pulse rate may increase somewhat; microtism is commonly seen. The headache may persist, but usually begins to diminish, the patient becoming dull and apathetic. In severe cases there may be delirium at night. Lips are dry and crack easily, tongue coated and becomes dry and discolored. If diarrhoea has been present the pea soup stool makes its appearance. Constipation is equally frequent and demands measures for its relief. The urine becomes scanty and may show albumen and a few casts. The spleen becomes enlarged. This is the second week of typhoid and it may end the period of high fever and the decline may begin. This, however, is unusual except in the typhoid of children. During this period death may occur due to intense toxemia, hemorrhage or perforation.

During the third week the symptoms continue, the patient gradually failing under the invasion. Towards the end of this period the temperature begins to show increased morning remissions and

\*Read before the Dade County Medical Society.



the pulse rate increases and keeps pace with the temperature chart. This is the period of the greatest danger from hemorrhage, perforation, broncho-pneumonia and other grave complications. Progressive asthenia or any of the complications can cause death.

The fourth week should be a period of the decline of all symptoms. The morning remissions in temperature become greater, the evening rise being less, so that there is a loss in temperature of about a degree daily, the reverse of the process during the first week. This fall by lysis is the rule but there are cases in which the temperature falls by crisis. Sudden falls should, however, be looked upon with suspicion as they may usher in a hemorrhage or collapse. The pulse becomes slower, the tongue moistens and the general condition improves. A rapid pulse at this stage denotes a myocardial insufficiency and exhaustion.

In the fifth week convalescence begins, the temperature falls to normal with excursions below the normal line, the appetite returns, nutrition improves. There may be desquamation and the hair commonly falls out. The spleen should no longer be palpable; if it remains large it is an indication that a relapse is probable. Slight recrudescences in the temperature are frequent; there may be a rise to 100 to 102 following some slight excitement or minor digestive disturbance which may last for a day or two.

This is in brief the usual course of the disease. The whole course is subject to the widest variations in the onset, the severity and the duration of the attack; again the whole burden of the attack may fall upon one system or organ, giving rise to a specialized character of the symptoms and course. Any intercurrent complication may take precedence and cloud the picture.

Instead of the usual insidious onset the onset may be abrupt. After no or insignificant prodromal symptoms the temperature may rise sharply to 102 or 103 with or without chill followed by sharp remissions or even intermission of the temperature during the first week. It may begin with pharyngeal symptoms and sore throat with swollen tonsils, naso-pharyngeal catarrh or infections in the accessory sinuses may be the earliest symptoms of any disease. There is an abdominal type of onset, sudden fever with nausea and vomiting accompanied by abdominal pain and rigidity closely simulating gastritis, appendicitis or a general peritonitis. There is a respiratory type in which there is an initial bron-

chitis of considerable severity, high fever with sweats, a rapid pulse and respiration with the physical signs of a general bronchitis which is very difficult to differentiate from pulmonary tuberculosis. In some of these cases there may be a rapidly developing pneumonia with a chill. The typhoid bacillus has been recovered from the lung in some of these cases, in others there would seem to have been a coincident infection. There is a renal type beginning with every evidence of an acute nephritis, scanty urine, albumin, blood and casts. And a nervous type closely simulating meningitis beginning with intense headache, vomiting, delirium, photophobia, retraction of the head and a positive Koenig's sign or drowsiness, stupor and coma may develop in a day or two. Cases beginning with maniacal psychosis and delusional states have been reported.

#### SPECIAL SYMPTOMS

The temperature curve is subject to great irregularities but in the main it is fairly characteristic and constitutes an important sign. The rise with the ascending oscillations increasing about a degree each day of the early part of the first week is frequently not seen, the onset is too insidious and we do not see our patients until the condition is well advanced. It is rare that the period of increasing fever lasts beyond the eighth day. During the second and third weeks the temperature remains at a high level with considerable daily remissions which tend to decrease during the third week. The fourth week brings increasing daily remissions and the period of the falling oscillations until the normal is reached. This period of descending oscillation is fairly constant, but cases have been observed to fall by crisis. The temperature chart is considerably modified by cold bathing, etc., but a sudden temperature change usually precedes or accompanies the onset of some complication. Severe hemorrhage commonly reduces the temperature several degrees, perforation may lower or raise it; pus infections cause wide variations, thrombo phlebitis is a common cause of such changes in the third and fourth weeks. The rise in temperature may begin several days before the local manifestations of the thrombosis become apparent. Hypothermia has been observed in protracted cases, sometimes persisting for a week or more. Complications and undemonstrable causes may and frequently do cause irregular oscillations of the temperature curve and serve to delay convalescence indefinitely. Recrudescence has been mentioned; the cause may be



slight or it may not be demonstrable. There will be an elevation of temperature to anywhere from 100 to 102 which persists for a day or so to a week and then subsides. True relapse is a question of reinfection. It occurs after the normal temperature has been regained for some days, the curve resembles in all ways the curve of the original infection except that the course is apt to be shorter. Relapse may occur before the temperature has reached normal in the original infection in which case it is called an intercurrent relapse.

*Chills.*—The chill has no particular significance at the onset of typhoid, but during the course of the disease they may usher in a complication of grave importance. They not infrequently result from the use of antipyrine and they commonly follow the hypodermic use of vaccine.

*Pulse.*—The characteristic pulse of early typhoid is slow in comparison to the fever. It tends toward dirotism rather rapidly. After the second week it becomes more rapid and follows more or less closely the temperature curve. The pulse curve is modified greatly by hemorrhage and perforation.

*The Blood.*—During the first few days the number of the red cells remains fairly constant, but there is soon a decrease which is accompanied by a corresponding decrease in the Hb index.

*White Cells.*—Leucopœnia is the rule and is usually an early symptom, the differential count shows a progressive reduction in the per cent of polys and a corresponding increase in the per cent of monos, particularly the large forms. During convalescence, a moderate leucocytosis may be caused by some secondary infection. Perforation is usually marked by a leucocytosis, with the onset of peritonitis, this is followed by a very rapid fall. In some cases where the patient is overwhelmed by the toxemia, the leucocytosis following perforation does not occur.

*Rash.*—This symptom is pathognomonic. It occurs from the seventh to the twelfth day. The spots are discrete, slightly raised, rose-colored and they disappear under light pressure. They are transient, occurring in successive crops, usually not more than 20 in each crop and frequently only five or six at any one time, each crop disappearing in 24 hours or less. Our experience leads us to believe that in the colored race, while the rash has somewhat different characteristics than in the white, it is more easily seen. We have observed small discrete glistening spots, the color of which is indistinguishable,

which are transient, occur in successive crops, disappear under light pressure, and are in all ways analagous to the rose spots, except in color, and are easily seen on account of their glistening appearance.

*Tongue and Mouth.*—The tongue in the early stages is covered with white fur and is moist, later it becomes dry and discolored. The oral secretions are diminished and sordes is apt to appear.

*Cough.*—Bronchitis is a fairly common early feature of typhoid, usually it is confined to the upper bronchi and gives rise to no symptoms other than a dry cough.

Constipation and diarrhœa are about equally common and they may alternate. If diarrhœa persists, the stools become large, thin, dull yellow in color and very offensive, during the second week, the so-called pea soup stool. Severe diarrhœa is an unfavorable symptom; it drains the body fluids, dries up the tongue and oral secretions, interferes with nutrition and aggravates the exhaustion and wasting.

*Abdominal Tenderness and Pain.*—This is usually present in some degree, it may be general or limited to the right lower quadrant. The pathology of the disease is a sufficient explanation for the existence of this symptom. As a rule it is not severe; it may be accompanied by rigidity and distension. There may be pain and tenderness over the enlarged spleen. Unusual pain may indicate perforation or hemorrhage.

Tympanites is usually present; if it is severe it may embarrass respiration and cardiac action. Under these conditions it interferes seriously with nutrition and predisposes to hemorrhage.

*Spleen.*—This organ is always enlarged, but it may not become palpable for several days after the onset. If the enlargement does not subside by or before the time the temperature falls to normal it is a valuable index of an impending relapse.

*Headache.*—This is a nearly constant early symptom. It varies in location, intensity and character, usually it persists through the first week and into the second and is followed by a state of mental torpor. If it persists beyond the second week it may indicate an infection of the meninges.

#### *Diagnosis.*

If we examine closely this mass of symptoms and the variants we are led to the following conclusions:

First. That the symptom complex varies to such an extent that in many mild atypical cases

the so-called pathognomonic symptoms do not occur or are so mild that they are not observed, while on the other hand no combination of symptoms is impossible.

Second. The symptoms which may be considered as distinctive are limited to

1. The rash, which is probably always present, but not always easy of observation.
2. Headache, which is fairly constant.
3. The temperature curve, which is a very valuable sign in retrospect.
4. Changes in the blood picture.

We should consider the possibility of typhoid in all acute febrile conditions and we have learned to suspect it in any case of prolonged fever not easily explainable on other grounds. An analysis of the symptom complex presenting may lead us to assume this diagnosis early in the disease, but it is perfectly evident that the diagnosis of typhoid fever can only be made or substantiated by the laboratory findings.

The diazzo reaction in the first two weeks is indicative but not positive. This reaction is found occasionally in many other conditions, among which can be mentioned diphtheria, erysipelas, pneumonia, scarletine typhus, the cachectic states like cancer, cirrhosis, syphilis, malaria and the grave anæmias.

The Widal test is specific if properly performed, but the agglutinating power of the blood is frequently very slow in developing; also it must be remembered in this connection that persons who have received the typhoid vaccination will show a positive or partial reaction.

*The Blood Examination.*—Repeated examinations showing a rapidly falling Hb index with a corresponding decrease in the red cells together with a develop in leucopœnia, the differential count showing a decreasing of polys and an increasing percentage of the large monos is very suggestive.

*The Blood Culture.*—This is the best evidence of all. The recovery of the typhoid bacilli from the blood is very convincing, and the fact that it will give the results early in the condition adds to its value.

Isolation of the bacilli from the stool is also positive evidence, but the inevitable mixed infection of all stool specimens complicates the situation, making the technique very difficult and the returns frequently unsatisfactory. It is easier and equally valuable from a diagnostic standpoint to recover the bacilli from the urine.

#### REPORT OF CASES

*Case 1.* Female, married, one child, age 23, fairly well nourished. Presenting symptoms: Sudden attack of abdominal pain, localizing in the right illiac fossa, boardlike rigidity of the right rectus, less tension on the left side, marked tenderness over McBurney's point accompanied by vomiting. Temperature 103.4, pulse 118, respiration 26. Physical examination, chest negative; absolute absence of prodromal symptoms, constipation, history of previous attacks of a similar nature. Working diagnosis: Acute abdomen, probably appendix. Blood count ordered with following report: RBC 4,418,000; Hb 86%. WBC 2800, polys 40 monos 58 trans 2. On the receipt of this report a Widal was ordered and was reported positive. This made the diagnosis.

This case ran a very mild course and was discharged from the hospital after only 16 days.

It illustrates the abrupt type of onset with abdominal symptoms. The presenting picture was that of an acute exacerbation of a chronic appendix. These symptoms, however, gave place to a dull apathy in something less than 24 hours.

*Case 2.* Man, age 33, married, one child, well nourished. For one week prior to June 20 complained of painful stiff neck and feeling of uselessness. No fever noticed until June 24. First seen June 24; temperature 103.4, pulse 90, respiration 20. At that time the physical examination of the chest and heart was entirely negative, the abdomen was moderately tender, gas movements were caused in the colon by palpation, the spleen was definitely palpable, and a few rose spots were observed. The tongue was coated, the appetite was gone and the laboratory reported a partial agglutination.

This man was admitted to the hospital June 25. On the twenty-sixth the hospital laboratory reported the following blood count: RBC 3,730,000, Hb 70, WBC 5750, polys 80, monos 20. On the 3rd of July the Widal was reported as negative and it did not become positive until the 25th and only then after the administration of typhoid vaccine. Albumin appeared in the urine for the first time on July 10, sixteen days after admission. On July 26, thirty-one days after admission, the blood count showed RBC 2,090,000, Hb 40, WBC 3,000, polys 60, monos 40. At about the same date the laboratory reported the recovery of typhoid bacilli from the urine.

The temperature curve in this case is very interesting. On admission to the hospital there

were daily oscillations of  $1\frac{1}{2}$  to 2 degrees, the temperature remaining between 101 and 103.6 for four days, then there was a rise with about the same sort of oscillations until on the 7th day it was 104.2. For four days more it remained at about this level. The chart is modified by cold sponging, of course, so that the oscillations remain about the same. On the 12th day there is a sudden drop of  $2\frac{1}{2}$  degrees accompanied by a rise in the pulse caused by a hemorrhage. Following this returned to about 103 and the oscillations became somewhat less and remained so for three days. During the whole of the next week the temperature remained at about this level, but the daily oscillations increased to about 2 degrees. In spite of the fact that on the sixteenth day there was another but smaller hemorrhage. From the twenty-third to the twenty-sixth days the temperature dropped daily about 1 degree each day. On the twenty-seventh day there was a sudden drop of  $4\frac{1}{2}$  degrees followed by hemorrhage and collapse; following this the

recovery was accompanied by a rise of temperature of 103.8 on the twenty-eighth day and 104.6 on the twenty-ninth and remained for three days at a high daily level of about 104. On the thirty-third day there was a sudden drop of 6 degrees. This was not accompanied by any demonstrable complication. By the following evening it had again gone back to 103, after which it remained steady from 102 to 103.6 for two days. On the thirty-sixth day moist rales appeared over the right chest and on the morning of the thirty-seventh there was an area of consolidation in the right lower lobe posteriorly, broncho-pneumonia developed and persisted for five days when the temperature began to drop by lysis. There were slight recrudescences on the forty-sixth and forty-ninth days, the cause of which was undetermined but which lasted less than 24 hours and the man was discharged on the fifty-fifth day, after having had a normal temperature for seven days.

## Looking Backward Over Fifty Years of Health Work in Florida

JOSEPH Y. PORTER, M.D.,

*Former State Health Officer of Florida,*

1889 - 1917

*Serial No. 4.*

The Legislature of 1889 convened in biennial session in April of that year. At which session separate resolutions were passed by both the Senate and the House, expressing to Dr. Porter the thanks and appreciation of the people of Florida through their Representative for his untiring energy and devotion to the sick of Jacksonville during the epidemic of yellow fever in Jacksonville and other cities of the state in the fall of 1888. They are mementoes greatly valued and sacredly cherished, carrying memories of incidents of loving sacrifice and devotion of a grief-stricken people.

The members for the State Board of Health provided for in the Legislative Act referred to, were almost immediately appointed by Governor Fleming, and Dr. R. P. Daniel of Jacksonville, with Messrs. W. K. Hyer of Pensacola and William B. Henderson of Tampa were the nominees. On organizing, Dr. Daniel was chosen as President of the board and the employment of State Health Officer was offered to Dr. Joseph Y. Por-

ter of Key West, an officer of the Medical Corps of the United States Army, who had been relieved from active duty in the army to await permanent retirement. A tentative opinion had been secured before the offer was made, from prominent legal authorities, that such employment would in no wise conflict with either Federal or state laws, for the reason that the position of health officer was not an office of the state in the strict meaning of the Constitution. An officer of the state must be either elected by the people, or appointed by the Governor, and in this instance the State Health Officer was neither, but was an employee of the board, at the board's discretion and sufferance. Dr. Porter was in continuous service from 1889 to 1917, when he resigned to enter the active service of the army in the World War.

Looking to the prevention of contagious disease entering the state by the way of the sea—maritime quarantine regulations—and specifying the duties of the State Health Officer, with no



precedents to follow or guide to direct administration of a methodical character, except those under which the Monroe County Board of Health and the Escambia County Board of Health had been operating, the task was a most difficult one; because seemingly the whole thought of the members of the board in health matters at that time was centered upon one subject, viz: to prevent yellow fever from again entering the state from Cuba, for this was apparent, as other equally as important matters pertaining to the general health of the citizens were held in abeyance for several years after. As will be mentioned elsewhere, the seaboard counties had quarantine boards of health, which actively operated in boarding of vessels entering the several ports of the counties during the summer season, but with the exception of Pensacola and Key West there was no systematic procedure of management. It became necessary, therefore, to adopt practical methods, based on a supposed knowledge of maritime sanitation at that time, that the health of the citizens of the state might be secured by uniform rules and regulations, applicable alike to all sections of the seaboard of the state. This likewise was a perplexing undertaking, because of divergent interests arising in different portions of the long coast line, for it must not be forgotten that Florida has a twelve-hundred-mile coast exposure to the tropical countries to the south, from which yellow fever had invariably been introduced.

As soon as money was available (for the first appropriation to cover two years of sanitary activity was only fifty thousand dollars), the State Board of Health built and equipped with modern disinfecting machinery approved of at that time, quarantine stations at the mouth of Tampa Bay, at Fernandina, Pensacola and at Key West. As will be mentioned hereafter in this story, Pensacola quarantine had already received considerable donations in money from the former Federal Board—the National Board of Health—and was functioning satisfactorily. Quarantine inspection stations were also designated for other minor ports of entry at that time, at Miami, Boca Grande, Charlotte Harbor, Cedar Keys, Anclote, and at St. Andrews Bay on the West Coast. These quarantine stations built by the funds of the State Board of Health continued to operate efficiently until 1901, when, as will be told hereafter, by an Act of the Legislature of that year, they were sold to the United States Treasury Department, and have since been conducted by the United States

Public Health Service. Money received from fees of inspection and disinfection served to defray the expenses of operation of these stations, thus lessening the maintenance cost to the state. The completion of the discovery by Nott and Finlay of the mosquito of a certain species, as the carrying host of yellow fever, and further establishing the fact by human experimentation, that “fomites” of yellow fever did not exist, made it unnecessary that expensive plants of disinfecting machinery should be extended and erected along the coast of Florida. The original method of fumigation against insects, by burning sulphur in pots in holds and living quarters of vessels from known disease-infected ports, is answering every requirement of protection.

The Presidents of the State Board of Health to the present time—May, 1925—have been Dr. R. P. Daniel of Jacksonville, Messrs. Wm. B. Henderson of Tampa, E. M. Hendry of Tampa, Frank J. Fearnside of Palatka, C. T. Frecker of Tampa, Joe Earman of West Palm Beach, and Dr. C. T. Young of Plant City, the present incumbent.

The State Health Officers from the organization to the present, have been Dr. Joseph Y. Porter of Key West, Florida, from 1889 to 1917; Dr. W. H. Cox of Brooksville, Dr. Ralph D. Green of Greenville, and Dr. R. C. Turck of Jacksonville, who is the present State Health Officer.

One of the first signs of general interest in sanitation on the part of the citizens of Florida as a community, was shown in the late eighties, during the latter part of the last century. The disastrous fire at Key West in the spring of 1886 had destroyed the whole of the business part of the city and a small portion of the residential. When rebuilding, the State Health Officer suggested to the mayor, then Hon. (Dr.) J. W. V. R. Plummer, that an effort should be made to install a system of sewerage before buildings were constructed, for the repair work to the city was rapidly progressing. Acting on that suggestion, Col. George E. Waring, an eminent sanitarian and civil engineer of Rhode Island, was invited by the mayor to visit Key West. Colonel Waring's efforts in perfecting a system of sanitary disposal of domestic wastes had then attracted attention for small cities and towns, which in working out had given satisfaction. Colonel Waring made not an instrumental survey of the city and island, but suggested a tentative plan by which sewage could be treated through

the septic tank plan and afterwards emptied into the sea by pumping. Funds were lacking, however, to carry out his recommendations, and consequently nothing was done at that time. The plan recommended by Colonel Waring, however, attracted the attention of the authorities at Tallahassee, and a septic tank system with trickling basins was installed at Tallahassee, which with increased units, as was demanded by the growth of the city, has operated successfully. Havana, Cuba, invited Colonel Waring to suggest improvement, for the sewerage system of that city was anything but satisfactory at that time. In making the survey of needed improvements, Colonel Waring unfortunately became infected with yellow fever, which developed on steamer going to New York, where he died a few days afterwards. Colonel Waring was the first martyr to a study in scientific sanitary work in Havana, and Dr. Jesse Lazier of Surgeon Walter Reed's organization was the second victim to a human demonstration of the transmission of yellow fever through the mosquito.

One of the great advances in marine sanitation in the quarantine system of the state occurred in the spring of 1887, when a steamship line was projected by the Plant Investment Company, Mr. H. B. Plant as President, for weekly communication between Tampa and Havana during the summer months of the year. The steamer "Mascotte" had been built at Philadelphia in the fall of 1885 and had been placed on the run between Tampa and Havana the following winter. The success of the venture had been so profitable as to induce the Plant Investment Company to make an effort to continue the service throughout the year. The Monroe County Board of Health had permitted communication with Key West and Havana the previous summer under stringent conditions of immunity of passengers and crew to yellow fever. Trade was not interrupted and as the passenger service was principally of the class who had experienced an attack of yellow fever, and could be vouched for to that effect, the danger of introducing yellow fever from Havana into Key West was reduced to a negligible quantity. The Plant Investment Company wished to avail themselves of a similar privilege and permit. The Monroe County Board of Health was willing because it had already tried out the plan, but the neighboring ports of Tampa and further up the peninsula, Jacksonville and Savannah, together with numerous railway points, demurred and strenuously objected to the Monroe County scheme. A consultation of

county and city health officers was called at Ballast Point, in Tampa Bay, in the spring of 1887, and representatives from Savannah, Jacksonville, Palatka, Sanford, Orlando and Tampa, and the principal cities and counties along the railway, met and discussed the situation, going very minutely into the probable danger of allowing communication with Cuba during the summer months. It was finally decided to adopt the Monroe County method and regulations of quarantine, and thus came into operation the "immune card" system of passenger travel and commercial trade between the State of Florida and the Island of Cuba during the summer months of the year, by the Plant Steamship Company, under the sanitary supervision of the Monroe County Board of Health.

Following the organization specified by the statute creating the board, an enlargement of administration was adopted by dividing the state into districts proportionate to population and appointing a medical man as an assistant to the State Health Officer, who should supervise the sanitary conditions of the district for which he had been selected. Most often an assistant was appointed for each county, but not infrequently two or more counties were combined into one district. These appointments were made conditional upon a professional examination, showing particular fitness and knowledge of preventive medicine by a committee of three disinterested physicians, who volunteered for the service. The compensation was contingent upon the service given, which included a per diem and travelling expenses when away from home. The system worked admirably, as monthly reports of the sanitary status of neighborhoods was furnished the board, which at the end of the year made valuable statistical health work, both instructive and interesting.

The next step in progressive sanitation was the organization in a similar manner of District Health Nurses, who, after successful mental examination conducted as that for health assistants, were assigned to different portions of the state, to oversee, instruct and direct a care of tuberculosis patients, and give information likewise to prospective mothers, for prenatal conditions, and in child welfare. The nurses were given a monthly salary with travelling expenses. The two plans of administration met with such satisfactory success that the scheme has never been materially altered, except in minor details, since the primary organization of the board.

*(To be Continued)*

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## THE WRITING OF ABSTRACTS FOR THE JOURNAL

Shortly after the annual meeting of the Florida Medical Association at St. Petersburg in May, 1925, the writer was selected by the newly elected Secretary and Editor of THE JOURNAL to establish a Department of Collaboration. Letters were addressed to many members of the Association soliciting cooperation and active collaborative service. Responses were hearty and enthusiastic. Additional correspondence welcomed wholeheartedly the members willing to assume the roll as abstractors of articles of special and general interest coming to their office.

All of which was very encouraging and led me to believe that the department was established and "ready to go".

In former correspondence I appealed to you individually and personally, and possibly it might be better to do that now, but it occurs to me that a collective appeal through THE JOURNAL would reach the cooperative consideration of the collaborating staff and relieve the busy editor of addressing collaborators and urging the early mailing of abstracts.

The abstracting department of THE JOURNAL is worthy of support and means a great deal to the members who wish to be advised of special articles in current medical literature. Those who make these reviews derive additional knowledge from the articles by the close perusal necessary to produce a concise abstract.

I am constrained to believe that the men who promised to do this work are conscientious and able and only need the urge of this editorial to remind them of their obligation. Send your abstracts to the editor before the first of every month, with a letter of hope and encouragement, telling him you expect to do better in the future.

R. H. MCGINNIS.

### DR. B. L. ARMS

State Health Officer

The high standard of efficiency maintained in the health affairs of our State under the competent leadership of Dr. R. C. Turck, has been influential in attracting residents to Florida from all parts of the nation. In laying aside the duties of State Health officer to enter another field, Dr. Turck carries the appreciation and confidence of the profession and the public.

In the appointment of Dr. B. L. Arms, by the State Board of Health, as the successor to Dr. Turck, we feel that the health matters of our commonwealth are placed under the direction of a well-trained, competent and conscientious man, and that our constructive program will achieve continued success. For twenty years closely identified with public health from Vermont to Texas and from Oregon to Florida, Dr. Arms assumes his new duties with an experience and a record of past achievement equalled by few men in this country.

Born at Springfield, Vermont, September 27, 1869, and receiving his preliminary education in the schools of that town, Dr. Arms was graduated in medicine from the University of Vermont in



the class of 1905 and began at once to lay the foundation for his future specialty by taking the service in Pathology at the Boston City Hospital for one year. For the next two years he was Bacteriologist, Boston City Health Department. In 1908 he became Assistant Director of the Bacteriological Laboratory, which position he held for two years, then becoming Director for three years (1910-13). During this latter period he was Instructor in Municipal Laboratory Methods, Massachusetts Institute of Technology.

Then he followed the admonition of one Horace Greeley and went West, where for one year he was State Bacteriologist for Oregon. The following year (1914) he taught Bacteriology in the University of Oregon as Assistant Professor.

Texas called and Dr. Arms accepted a chair in the University of that State, as Professor of Preventive Medicine, which position he held for two years, 1914 to 1916.

By a circuitous route, but still on the way to the "Land of Flowers", he spent a year in Alabama as State Bacteriologist, and finally reached his goal in 1917, when he was called to Florida as Director, Bureau of Diagnostic Laboratories, State Board of Health. To Florida they come, they look, and they stay and so the doctor stopped his ramblings.

Dr. Arms holds fellowship in the American Medical Association, American Public Health Association, and in the American Association for the Advancement of Science. He is a member of the American Association of Pathology and Bacteriology and the National Committee on Milk Standards.

In Dr. Arms there is combined the astuteness of the scholar, the exactness of the scientist, the diplomacy of the executive, and the charm of the gentleman. To the State Health officer of Florida we extend greetings, confidence, and our cordial good wishes for a successful administration.

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#### STATE NEWS ITEMS

*This department is supervised by Dr. Ralph N. Greene, Jacksonville. Members of the State Association are requested to forward to Dr. Greene or the Editor such news items as they may think of interest to the readers of THE JOURNAL.*

Drs. R. L. Harris and W. J. Buck, who have been associated in the practice of Roentgenology,

Jacksonville, have dissolved partnership by mutual agreement. Dr. Harris will continue the practice of Roentgenology in the Professional Building, Jacksonville.

Dr. John S. McEwan of Orlando, President of the Florida Medical Association, has recently returned from an European trip. He reports a most interesting sojourn.

Doctor W. H. Ellis, formerly of Georgia, is now associated with Doctor C. E. Tumlin, 15 N. E. 11th St., Miami. Doctor Ellis is now away on a vacation but will return the latter part of September, at which time he will bring his family with him, as he expects to remain in Miami permanently.

Doctor W. A. Haggard and family, of Ridewood, Alabama, have located in Miami and are enjoying the prospects of their new home. Doctor Haggard will be associated with Doctor C. E. Tumlin.

Doctor C. E. Tumlin of Miami, with his wife and daughter, Marjorie, recently enjoyed a vacation at Asheville, N. C., having motored both ways, stopping en route in Atlanta and Jacksonville.

The DeSoto Commissioners at Arcadia have called an election for October 20th, to vote on a three million dollar bond issue for the purpose of building and equipping a county hospital. It is stated that the present hospital is wholly inadequate, although in the past it has rendered a great service to suffering humanity. The old hospital is occupied beyond the limit. The nearest hospital to Arcadia on the north is at Lakeland, and on the south at Fort Myers. During the first six months of 1925 eighty-three major and one hundred and fifty-three minor operations were done at the Arcadia General Hospital, in addition to which a large group of medical cases were treated. The medical profession of DeSoto County is united in favor of the proposed bond issue.

Doctor H. Marshall Taylor, 111 W. Adams St., Jacksonville, has returned from a European postgraduate trip extending over a period of ninety days. Doctor Taylor was accompanied by his family, and the party visited England, France, Germany and Austria. Doctor Taylor reports excellent clinic facilities, particularly at Vienna.

Doctor James Fellows of Pensacola is spending the month of October in New York City, pursuing special studies in Pediatrics. Doctor Fellows enjoys a large pediatric practice in Pensacola.

Doctor B. F. Barnes of the State Hospital at Chattahoochee, was recently in attendance upon the National Radio Exhibition held at the Grand Central Palace, New York City. Doctor Barnes is a recent recipient of an expensive and complete radio equipment, presented to him by one of the large radio manufacturers in appreciation of his developmental effort in the science of radio transmission.

Doctor H. Mason Smith of Tampa, a recently appointed member of the State Board of Health, has just returned from a trip to Baltimore and New York, where he attended clinics in a number of the larger hospitals. Doctor Smith has been particularly interested in nutrition problems relating to neurological diseases.

Doctor J. Q. Folmar, Chief Physician, State Hospital at Chattahoochee, has recently returned to Florida following a special course in neurological surgery at one of the leading New York hospitals.

Doctor Luther Holloway of Jacksonville, has recently returned from a visit to the Pediatric departments of John Hopkins Hospital and New York Post-Graduate Hospital.

Doctor Wm. E. Ross of Jacksonville is now in New York on his annual vacation and is, incidentally, in attendance upon pediatric clinics at one of the large Eastern hospitals.

Doctor W. M. Rowlett, Secretary of the State Board of Medical Examiners, is on his annual vacation in New England. Doctor Rowlett will return to his practice in Tampa on or about November 1st.

Doctor F. F. Farris, formerly of Florida, but more recently engaged in Eye, Ear, Nose and Throat practice in Cincinnati, will soon locate in Miami for the purpose of continuing his specialty there. Doctor Farris was formerly one of Florida's leading physicians and financiers. He was owner of the Leon Hotel in Tallahassee and the Palms Hotel in West Palm Beach.

Doctor James R. Bean has assumed his duties as Senior Bacteriologist of the State Board of Health of Florida. Doctor Bean is well known by the Florida profession, and his appointment by the recently selected state health officer, Doctor B. L. Arms, will meet with universal approval. The Florida State Board of Health boasts of the most complete chain of state laboratories of any state in America.

Doctor G. E. Weems of Apalachicola was a recent visitor in Jacksonville on account of the

illness of Mrs. Weems, whose numerous friends will be pleased to hear of her satisfactory convalescence from a serious illness.

Several Florida physicians are reported to have made amounts ranging from one million dollars down to one hundred and seventy-five dollars on real estate investments. Their names will be withheld from these columns in the future, as it is not the desire of the editor of this journal to complicate these gentlemen on their income tax reports. If all the stories about doctors making money in real estate are true, the United States can safely cancel all of its foreign assets in the way of war loans, for the doctors will surely pay in enough money to the Treasurer of the United States to meet any and all emergencies for years to come.

Doctor H. F. Watt of Ocala was recently called to Chicago on account of the serious illness of his mother.

Doctor and Mrs. J. Harry Walters of Ocala enjoyed the month of August recreating in the mountains of North Carolina.

Doctor W. K. Lane and family of Ocala recently returned from an extended motor trip to Pennsylvania.

Doctor Albert H. Freeman, formerly of Jacksonville, is now located in Ocala, limiting his practice to the diseases of the eyes, ears, nose and throat. Doctor Freeman is a past president of the State Medical Association and one of the most capable doctors in Florida.

Doctor E. G. Peek of Ocala was recently reappointed by Governor John W. Martin, a member of the State Board of Medical Examiners. This is Doctor Peek's third appointment to membership on the State Board of Medical Examiners.

Mrs. Dozier, wife of Doctor H. C. Dozier of Ocala, is reported as making satisfactory convalescence from a recent very serious operation at the Marion General Hospital, Ocala.

Twenty-five members of the Orange County medical society, comprising Orange, Osceola and Seminole counties, recently gave twenty-four hours for each member in the boy scout encampment of the Central Florida Council at Plymouth, looking after the health of the camp and giving personal instruction.

Doctor H. W. Gwynn of Orlando is spending three weeks in the clinics of New York.

Doctor Craney of Orlando is spending two months in Denver, Colo., studying diseases of the lungs.

Doctor John S. McEwan of Orlando, President of the Florida Medical Association, is reported to have admitted kissing everything else except the "Blarney Stone", which stone he also honored with the typical American salutation. Doctor Holton is with Doctor McEwan in Paris, and they are said to have concluded that Atlantic City and New York are wonderful but are particularly attracted to Paris.

Dr. and Mrs. C. C. Webb are receiving congratulations on the arrival of another daughter.

Dr. M. A. Lischkoff of Pensacola was among those attending the American Academy of Ophthalmology and Oto-laryngology, in Chicago. He states that many of the members were already interested in Florida and more would be soon.

Dr. W. C. Payne spent a few days in New Orleans investigating heliotherapy.

Dr. Evan L. Huggins of Freeport has been a frequent visitor to Pensacola. The Pensacola Hospital and an active real estate market are two attractions hard to resist.

Dr. J. H. Pierpont has returned from a pleasant motor trip through the mountains of North Carolina.

The Escambia County Medical Society and the staff at the Pensacola Hospital have begun their regular meetings after the usual summer vacation.

Dr. Shaler Richardson, Jacksonville, is attending the meeting of the American Academy of Ophthalmology and Oto-laryngology, being held in Chicago, October 21-24. Following this he expects to go to Philadelphia for the session of the American College of Surgeons.

## STATE BOARD OF HEALTH NOTES

Dr. Jas. R. Bean returns to the Laboratories of the State Board of Health after an absence of nearly nine years.

During the interim he was for two years in the service, and for fifteen months of this time he was overseas, being divisional epidemiologist with headquarters at St. Aignan.

He was for four years located at Birmingham, Alabama. Before going into service at Birmingham Infirmary and after his return was in charge of the Jefferson County Laboratory. This Laboratory was a combined county, state and city Laboratory, for in Alabama a county is the unit for all health endeavor, i.e., the county health officer is also health officer of every city in that county, and the other lines of health work are also on the county plan, although a city may supplement the county appropriation for strictly city measures such as, from the laboratory standpoint, milk examinations.

At the time of the reorganization of the Health Department in Savannah, Dr. Bassett secured Dr. Bean's services to direct the work of the Laboratory Division of that city.

We are glad to welcome to the State Dr. E. C. Levy, the new health officer of Tampa, and we congratulate that city on its farsighted investment.

Dr. Levy's pioneer epoch-making work at Richmond is well known to all public health workers in that country, and that his work has been appreciated by his fellow-workers is borne out by the fact that he has served as president of the American Public Health Association.



## ABSTRACT DEPARTMENT

## SURGERY

Reducing the Surgical Risk in Some Gastro-intestinal Conditions, Orr, Thomas G., and Hayden, Russel L. *Journal of The American Medical Association*, 1925, Vol. 85, No. 11, page 813.

As a part of a Symposium, having to do with the general subject of poor surgical risks, and methods which have been developed to combat the elements of the cases producing the risks, this paper, from the University of Kansas School of Medicine, brings again to our attention some of the newer therapeutics, built upon the solid foundation of Physiology, and directed to the reduction of mortality in one of the most distressing and disheartening problems arising in surgical practice, namely, intestinal obstruction.

Orr and Hayden, having their attention drawn to blood chemistry in gastro-intestinal tract obstructions, by three cases of gastro-enterostomy presenting stormy symptoms, found that the blood showed in each case, a marked increase in nonprotein nitrogen, a fall in chlorides and an increase in the carbon dioxide combining power of the plasma.

They then proceeded to study, experimentally, the blood chemistry in animals, mostly dogs, in cases of pyloric and upper intestinal obstruction, and found a universal rise in the nonprotein and urea nitrogen, and in the carbon dioxide combining power of the blood, and a drop in the chlorides. There was also a constant similar change in the urine in the experimental animals.

Experiments were then done, properly controlled by control experiments, in replacing the chlorides of the blood, both before and after the onset of the symptoms of intoxication in the dogs, with artificially produced obstructions of the duodenum and jejunum. The dogs with obstructions untreated, and those treated only with distilled water injections, died in from three to eight days. Those treated with replacement of the chlorides by hyperdermoclysis of normal sodium chloride solution, and by stronger chloride solutions, did not develop the typical blood changes enumerated above, and lived from twenty to thirty days.

The experimental studies are backed up by brief references to a few cases studied and treated along the same lines with gratifying results.

The authors conclude that the chlorides seem to be the essential factor in the occurrence of and in the treatment of the toxæmia incident to

high intestinal obstruction; that a drop to 400 in the blood chloride of a case of intestinal obstruction should be the indication for the generous administration of sodium chloride, and that it is best given in 1 to 2 per cent strength, subcutaneously, or 5 per cent intravenously, the amount being gauged by the blood findings of the individual case. They have estimated a dose of 1 gm. per kilo of body weight as an initial dose in very toxic cases.

J. K. S.

Fractures of the Lower End of the Radius, by Ralph M. Carter, Green Bay, Wis. *Surgery, Gynecology and Obstetrics*, 1925, No. 3, page 287.

The author presents a comprehensive study of a type of fracture which occurs very frequently in the experience of practitioners and surgeons. He maps out in detail a thorough method of treating them. First, there is a review of the anatomy of the elbow and wrist. Then follows a discussion of the three most popular theories of the mechanism of the force causing these fractures:

"1. The force is transmitted by means of bony segments exclusively, no ligaments being involved.

2. The force is concentrated upon the anterior radiocarpal ligament, which tears off a fragment.

3. The force follows a complex course from humerus to ulna, and from ulna to radius by means of the interosseous membrane."

The author believes there may be a combination of these mechanisms and at times also an impact of the carpal bones against the lower end of the radius, with damage to the ligamentary apparatus of the wrist.

The matter of diagnosis is usually not difficult, especially with the aid of x-ray examination. Though no line of fracture may be demonstrable the plane of the articular surface of the radius with the carpus is helpful in diagnosis. Reduction should correct any deviation from normal in this plane.

The treatment recommended is as follows:

1. Reduction under general anæsthesia. First by hyperextension of the wrist, then by pressure over the distal fragment to force it into position.

2. Apply light anterior and posterior splints with hand in position of adduction, one-half way between pronation and supination. Do not use

a plaster cast. Be careful of pressure by the splints.

3. Institute massage and motion. Begin gentle massage and passive motion on the third or fourth day. To do this remove dressings completely. Repeat every other day with gradual increase in the length of treatments. By the tenth day the anterior splint may be discarded, the posterior by the third week. Then support wrist with bandage of adhesive. Carry arm in sling so that hand naturally falls in position of adduction. At end of fourth week permit the patient to perform light household duties; at six or eight weeks to do usual normal labor; and in ten or twelve weeks to use wrist for heavy lifting.

E. J.

### MEDICINE

**Increased Permeability of Vessel Walls as a Frequent Cause of Pulmonary Hemorrhage, F. M. Pottenger, M. D.** *The American Journal of the Medical Sciences*, No. 642, Vol. CLXX, No. 3.

Dr. Pottenger remarks on the frequency of blood spitting in pulmonary diseases, particularly tuberculosis.

Formerly blood in the sputum was supposed to indicate destruction of a portion of the wall of the pulmonary vessel. Recent more careful observation of tuberculous patients indicates definite underlying causes. Ulceration of the walls of the vessel injured and the closing of returning capillaries, changes in the weather, presence of acute respiratory infection and the menstrual cycle are counted as underlying causes.

He calls attention to the frequency of blood spitting in tuberculous patients during menstrual period. This has been called Bicarious Menstruation. This is an incorrect explanation.

Different observers have called attention to the present relationship between hemorrhages and the presence of pneumococci and other organisms causing acute respiratory infection. This is well established. Browning's observations indicate relationship between pulmonary hemorrhage and barometric changes. Krogh has discussed the effect of capillary poisons which cause dilatation of the vessel walls and permit a ready passage of the contents of the blood into the tissues.

He summarizes his paper by saying that acute infections of the lung are apt to produce their greatest effect at the point where the tissues are now or have been injured by tuberculous process. The menstrual enzyme, in some manner, causes increased activity in local tuberculous processes.

Certain weather changes, the exact factors in which we do not know, affects all tissues of the body, particularly the lung. T. Z. C.

**The Value of Iron in Anemia. An Experimental Study, by Charles Spencer Williamson, M.D., and Harold N. Ets, M.S.** *Archives of Internal Medicine*, No. 3, Vol. 36.

He discusses the question of absorption and utilization of iron in the formation of hemoglobin. He calls attention to the fact that the results of researchers have not been in accord.

He calls attention to the studies of Bunge and Haeusermann, analyzes the studies, pointing out the defects in their research work. Whipple and his associates have studied the question and shown that diet of animals was of greatest importance, and have given no support to the value of inorganic iron in simple anemias. Musser's studies fail to show any favorable influence in organic iron in experimental hemorrhagic anemias. Scott and Barcroft state that iron seems to "anticipate the cure, which occurs normally". Gibson and Howard still feel justified in the continued administration of iron in the form of Bland's Pills.

The author undertook his experimental studies after selecting animals that could be obtained in large numbers in large litters, to use animals in sufficient numbers, a standard Basal diet adequate in all respects, a proper method of determining the hemoglobin. The method chosen to determine the hemoglobin was the spectrophotometric method. Rats and dogs were used for his experimental work. Various diets were arranged with the amount of iron in each diet accurately determined. The first series of forty-five rats were divided into two groups, one-half of each litter placed on standard iron-free diet and half on the diet containing iron which was described. This group was continued for six and one-half months. The second group of thirty-six were carried in this for four and one-half months. The third group of eighty-five for three months. The fourth group had 28 per cent of their blood volume removed and were placed on the same diet for various periods. A second group of forty-one rats had 2 c.c. blood removed from the heart and then placed on diets. Group six of sixty-two rats was used to test the value of iron hypodermically. Group seven of sixty-one rats were used to determine whether the young rats that had been kept on an iron-free diet during gestation and lactation would have a lower hemoglobin concentration than those born of dams

that had been kept on such a diet plus medicinal iron during the same period.

Further experiments were carried out on dogs. Altogether, there were four groups of dogs.

His conclusions were:

1. Inorganic iron, whether given by mouth, subcutaneously or intravenously, is absorbed and may be found especially in the liver and spleen but is not converted into hemoglobin.

2. Animals made anemic by one or several large bleedings do not recover any more rapidly when inorganic iron is given in any of these ways.

3. The efficiency of food iron is very pronounced, and animals on a diet containing food iron, recover very rapidly from hemorrhages that remove an amount of iron greater than exists in the entire body outside the blood.

4. In the light of the foregoing experiments, the administration of inorganic iron has no therapeutic value in anemia.

T. Z. C.

#### DERMATOLOGY

*Pityriasis Rosea, Two unusual cases.* D. W. Montgomery, M.D., and G. D. Culver, M.D. *Archives of Dermatology and Syphilology.* Vol. 12, No. 2, page 257.

It has long been observed that the disease is of the immunizing type, i.e., one attack is rarely followed by another. In the first case reported, a typical attack followed by a large herald patch on the cheek of a patient, who had the disease ten years previously. The disease was diagnosed at that time by an eminent dermatologist, and the patient was satisfied that the present attack was the same as the previous trouble. The second case again proved the exception by being intensely pruritic in character, so much so, that a confrere had made a tentative diagnosis of scabies. Subjective symptoms are ordinarily lacking.

The author concludes that apparently pityriasis rosea is an immunizing infective disease, which is self limited, and if infectious, is selectively so. In spite of self limitation treatment is of value.

J. L. K.-S.

#### OTO-LARYNGOLOGY

*A Review of Radiotherapy for Chronic Tonsilitis.* James W. Babcock, M.D., *New York Annals of Otolaryngology*, September, 1925. Vol. XXXIV, No. 3, page 834.

The treatment of Chronic Tonsilitis by X-Ray is presented in a digest of forty-nine articles occurring in the literature during the past three or four years, with personal observations and histories of ten cases from the practice of Dr. C. G. Coakley and the author.

The writers favorable to radiotherapy are of the opinion:

1. That X-Ray avoids operative risk, undoubted tho small.

2. Reduces the size of tonsil by diminution of lymphoid tissue with increase in connective tissue.

3. Returns the tonsil to appearance of health and normal function, eradicating the focus of infection by widening and lessening the depth of the crypt and freeing them from pathogenic bacteria.

4. Acts favorable on adenoid tissue and other lymphatic structures which are difficult to remove surgically.

5. Number of treatments are from one to eight.

The writers unfavorable to X-Ray treatments maintain:

1. That size is not a factor when determining the amount of damage done by diseased tonsils. That the portion showing behind the anterior pillar is erroneously considered as index of size of whole tonsil, and that X-ray produces a retraction of the tonsil rather than a real decrease in size.

2. That if radiotherapy destroys the lymphatic tissue to replace it with scar tissue, what becomes of any suppositious endocrine function?

3. That the tonsil is not freed of pathogenic bacteria.

4. That patients improved with radiotherapy are apt to have recurrence of symptoms.

5. That dryness may result and that indications for elimination of tonsil infection do not allow protracted courses of treatment without danger.

The author's case records are not encouraging for X-Ray, local symptoms recurring and focal general symptoms persisting until surgery was resorted to. He concludes with his own observations that:

Radiotherapy in chronic inflammation of the lymphoid tissue of the pharynx and naso-pharynx does not

1. Cause a disappearance or fibrosis of this tissue.

2. Render the crypts of the tonsil free from pathogenic bacteria.

3. Relieve the patient of acute local inflammation or the remote symptoms due to absorption of toxins or bacteria from the tissue in question.



Therefore does not accomplish the effects chiefly desired and cannot replace adequate surgery.  
J. L. B.

### PEDIATRICS

The Treatment of Thrush with Gentian Violet. Harold K. Faber and Lloyd B. Dickey. *Journal A. M. A.*, Vol. 85, Sept. 19, 1925.

In an epidemic of thrush affecting fifteen infants in an institution the authors found astonishing results from the use of a 1 per cent aqueous solution of gentian violet without supplementary washes. The solution was painted on the buccal mucous membrane once a day, midway between feedings. From one to three applications were all required and a cure was effected in from one to three days. It is recommended that this solution be employed as a prophylactic measure in hospitals or institutions in which an epidemic of thrush exists.  
J. D. L.

Vaccine Therapy. The Method of Choice in the Treatment of Whooping Cough. Charles J. Bloom. *Archives of Pediatrics*, Vol. XLII, August, 1925.

The author furnishes result of his observations from 1916 to the present time. He is especially sure of the value of pertussis vaccine in the prophylaxis of whooping cough and presents figures to prove its value.

In the treatment of the disease his results are decidedly good, since the average duration of the disease was about 21 days and complications exceedingly infrequent. He employs for both preventive and curative purposes a mixed vaccine, each c.c. containing 5,000,000 pertussis vacilli and 3,500,000 influenzæ bacilli. The vaccine should by preference be freshly prepared, not over two weeks old, and in order to give the vaccine a fair test we must have some laboratory producing vaccine every week. In the series of cases reported an average of four injections of 1 c.c. were required. Of 374 cases reported there were no deaths. Practically no internal medication was employed.  
J. D. L.

"A study of the Relative Value of Two Breads in the Nutrition of Children", Dorothy C. Chidlow. *Archives of Pediatrics*. Vol. XLII, August, 1925.

For purposes of observation a number of children in an institution were fed on a diet including ordinary white bread and others on a diet including a special germ bread. The germ bread was compounded approximately of 18 parts wheat embryo and 82 parts white flour. The observa-

tions were exhaustive, impartial and conclusive. The children fed on germ bread gained faster in weight and showed more physical vigor than those fed on ordinary white bread. This is probably due to the greater amounts of vitamins A and B and iodine found in germ bread. The article contains a foreword by Dr. George Fiske in which he deplores the universal use of white bread, which constitutes one-third of the diet of the major part of the population, and a warning that if this continues it is only a question of time when there will be a deterioration of the race, not only in numbers but in all else that makes for national greatness.  
J. D. L.

### SPECIAL PULLMAN TO DALLAS, TEX.

On account of the annual meeting of the Southern Medical Association, Dallas, Texas, Nov. 9th-12th, special rates have been made by practically all railroads at one-half fare for the round trip; tickets on sale from Nov. 5th-11th; final limit, Nov. 18th. It will be necessary for members to secure Identification Certificate from Mr. C. P. Loran, Secretary, Birmingham, Ala., in order to secure the reduced rates. When certificate is secured, present same to your Ticket Agent and he will sell you round trip ticket to Dallas at one and one-half fare.

Special Pullman will leave Jacksonville via the Southern Ry. "Kansas City-Florida Special", 9:00 p.m., Nov. 7th; leave Atlanta 7:00 a.m., Nov. 8th; Birmingham, 12:30 p.m. and arrive Memphis 1:30 p.m. Leave Memphis via the Missouri Pacific "Sunshine Special", 11:15 p.m. (sleeper open 9:30 p.m.), and arrive Dallas, 1:15 p.m. Monday, Nov. 9th, in ample time for members to secure hotel accommodation, register and attend any special entertainments during the afternoon and evening.

Those who desire Pullman accommodations in the Special Pullman leaving Jacksonville on above schedules, should write Mr. V. L. Estes, Division Passenger Agent, So. Ry., Jacksonville, stating kind of reservations desired, and same will be handled promptly.

Members from Georgia, Alabama, Tennessee, Virginia, North and South Carolina, will use the above route and schedules, and it is expected there will be enough business out of Memphis for a special train to Dallas.

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# THE JOURNAL

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## REPORT OF AN UNUSUAL CASE OF INTESTINAL OBSTRUCTION\*

L. J. EFIRD, M.D.,

Tampa.

Intestinal obstruction is either dynamic or mechanical. The mechanical form may be the obturation, or the strangulation form. Dynamic obstruction depends simply upon the failure of the contractility of the intestinal wall to overcome the resistance offered. The mechanical obstruction postulates the presence of an actual mechanical force intervening to prevent the flow of the fecal current. The great majority of cases of dynamic ileus owe the failure of power to the paralysis of the bowel wall most frequently due to peritonitis. The obturation form is simply the closure of the bowel for the passage of the fecal current with a minimum amount of injury to the intestinal wall itself. Strangulation of the bowel includes not only obturation but also compression of the wall of the intestine giving rise to interference with the blood and nerve supply of the bowel.

The following case was undoubtedly an obturation form, to begin with, and later became one of strangulation type. This patient was a white woman, sixty years of age, who came under my care November 14, 1924. She had been operated on for an undetermined type of abdominal tumor in September, 1923, in Philadelphia, by Dr. Tracy. When I saw her, she had a sinus at the lower angle of her incision which was draining considerable muco-pus. A letter from her physician stated that she had been operated for a supposed ovarian cyst, but when the abdomen was opened he found a very unusual condition of things—that there were strong adhesions everywhere—bowels, omentum, etc. He was unable to remove the sac but released all the adhesions possible. A culture made showed it to be a tubercular condition.

On examination this patient was emaciated and anaemic—her weight was 102 pounds, her heart was normal and of regular rhythm, her chest was negative for any pathology. Liver, kidneys and spleen were apparently normal in

size and position. Her urine was negative. Blood picture was of no consequence except a 65% hemoglobin and a red count of 3,800,000. Examination of the abdomen disclosed a tumor mass reaching up to within two inches of the umbilicus. There was a slight enlargement of the lymphatic glands especially marked in the inguinal region.

The patient complained chiefly of debility, poor appetite and inability to properly digest her food, extreme constipation and tenderness around the discharging sinus. She was advised to stay in the fresh air and sunshine as much as possible, to take plenty of nourishing and easily assimilated food, and to take mineral oil in sufficient quantities to insure a soft easy movement every day. Under this regime she improved quite rapidly, gained considerable in weight, but the sinus continued to discharge.

In January, 1925, she came in hoping that something further could be done to either remove her tumor or at least close up the sinus. I advised her against any further operative treatment, but suggested that she have some deep X-ray therapy. On this advice she took two series of treatments without any apparent benefit. February 15th, shortly after her last X-ray treatment, she began to have considerable pain in her abdomen and vomiting. She prescribed for herself after getting no results from her mineral oil, and took all kinds of purgatives, all of which she promptly vomited. I was called to see her on February 18th and found her vomiting constantly material of a fecal nature and having a great amount of pain. I gave her a hypodermic of morphine, sent her in to the hospital, with the idea of trying to relieve what I believed to be intestinal obstruction. She vomited only one time after getting into the hospital, but this was strictly fecal material. I saw her one hour later, at 9 o'clock, and she was so much more comfortable than she had been for three days, according to her statement, that I deferred operation. I saw her again at 11 p. m. when she was sleeping and her general condition satisfactory. Next morning at 6 o'clock she discharged a great quantity of fecal material through her fistulous opening. I believed, of course, that this spontaneous rupture of the gut into the sinus had temporarily

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg May 19-20, 1925.



saved her life. Her bowels continued to move through this tract and a few days later we had some X-ray pictures made following a barium meal, to determine the point of rupture in the ileum. These pictures were very unsatisfactory and could give us no information, but fearing that her spontaneously produced ileostomy was so high up in her ileum that she would not be able to be properly nourished, we resorted to rectal feeding, and also gave her whey, junket, peptonoids and plenty of water by mouth.

Nine days after her rupture, she suffered considerable pain, with very slight fecal discharge from the sinus. On examination I found that the opening was completely blocked by a slough. I took hold of this slough with a pair of forceps and gradually extracted between five and six inches of necrotic bowel. I at first thought that this was a part of the omentum, but on close inspection it proved to be intestine. The next morning while the nurse was doing her dressing she extracted another portion of necrotic bowel between six and seven inches long. This is the only case that I have ever seen or heard of in which the patient's intestines actually sloughed out.

Up to this time the patient's general condition was unchanged except we noticed that she was getting thinner and believed that she was not being sufficiently nourished, so in consultation with Dr. Hardy, we decided to open the abdomen at a point distant from the sinus and try to anastomose a healthy portion of the ileum with the colon. At operation we found everything simply one mass of adhesions and were unable to do anything at all but close up.

She continued to live until April 19th, when she died of inanition. I might add that her incision healed very promptly by first intention and that she left the hospital on April 1st and even recovered sufficiently to be up and around the house part of the time.

#### DISCUSSION

*Dr. E. W. Hardy, Tampa:*

On account of the lateness of the hour, I am going to confine my remarks to two points—first to thank Dr. Efrid for allowing me to see this case in consultation, and second to call your attention to the two main features in the case: First, the spontaneous enterostomy. Second, the sloughing of the bowel. I have had very little experience with either of these conditions and would like to hear some discussion very much.

*Dr. Joseph Halton, Sarasota:*

Without going far into this discussion, I just want to mention the point that frequently a great amount of trauma sometimes can occur to an intestine and still have the patient survive, and then again how easily may some slight infection cause the patient to die of generalized peritonitis.

#### CLINICAL ASPECTS OF ADENOMYOMA

W. M. JORDAN, M.D., F. A. C. S.

Miami.

Broadly speaking, adenyoma, or more properly adeno-leio-myoma, may be defined as a relatively small new growth composed largely of smooth muscle fibres and groups of tubular glands identical in structure and function with those of the uterine mucosa. The distribution of these tumors, as a rule, bears a more or less close anatomic relation to the female genital tract, though they have been found in structures as remote from this tract, physiologically, as the umbilicus and vermiform appendix.

The glandular tissue of adenomyoma behaves during menstruation as if it were an integral part of the uterine mucosa. That is, the gland spaces of the tumor, though disconnected with the uterine canal, become gorged with menstrual blood which has no means of escape except through the slow process of absorption. Tension in the cystic spaces becomes excessive, and the resulting pain intense. In this way, adenomyoma gives rise to its characteristic symptom—severe menstrual pain.

Historical data and detailed discussion of the various theories relating to pathogenesis do not properly come within the scope of this paper. This ground is thoroughly covered by M. R. Robinson in a recent notable article, (S. G., & O., July, 1925), together with his own conclusions. It should be consulted by those who are interested in the controversy relating to the genesis of these tumors. I am indebted to him for the brief historical matter included herein, and especially for his clear analysis of the views advanced by the German school—Rokitansky, von Recklinghausen, Myer, and others. The work of the American pioneers in this field, Cullen and Sampson in particular, is familiar to all who are interested in pelvic surgery.

Adenomyoma was first described by Rokitansky in 1860. However, his work aroused neither pathologic interest nor clinical enthusiasm for more than thirty years. In the late nineties, after

von Recklinghausen had published his studies and advanced the theory that adenomyoma was of embryonal origin and sprung from displaced tissue from the Wolffian duct, the subject began to attract attention and a voluminous literature has gradually accumulated. The pre-eminent American authority is Thomas S. Cullen, whose first paper appeared in 1896. Since then, and up to the present time, Cullen's contributions have been among the most widely quoted in the literature, both in this country and abroad. Cullen holds the view that the gland tissue of adenomyoma is derived, not from the Wolffian duct, but from aberrant remnants of the Muellerian duct or its equivalent, the uterine mucosa. John A. Sampson, whose studies relate chiefly to adenomyomatous cysts of the ovary, believes that the gland tissue arises from endometrial implantations that escape from the fimbriated end of the Fallopian tube. Robinson, after a critical review of previous theories, and in the light of his own researches, concludes that a more primitive embryonic structure, the coelomic epithelium, is the probable source of the adenomyomatous tissue, which he calls "heterotopic endometrial proliferations". Thus it will be seen that while all are agreed that the gland tissue of adenomyoma is essentially endometrial or Muellerian in type, there is controversy as to whether it is always of embryonal origin, and if so, as to what particular embryonic structure it is derived from.

Pathologically, adenomyoma consists of groups of gland tubules associated with a mass of smooth muscle fibres. The glandular elements conform closely to those which line the normal uterine canal, both in structure and function. Hence it follows that menstruation takes place in the gland spaces of the tumor in the same relative degree that it does in the uterine cavity, and at the same time. But since there is no outlet, ordinarily, for the menstrual blood in the glands of the tumor, it must undergo partial absorption in the inter-menstrual interval, or find an outlet by perforation. The tumor gradually assumes the character of a thick-walled cyst with dark fluid contents—the so-called "chocolate cyst". These adenomyomatous cysts exhibit a remarkable tendency towards perforation into the peritoneal cavity or into adjacent organs, as the rectum or bladder. I believe that this perforative tendency may be largely dependent upon gradual erosion of the encapsulating tissue, due to the lytic property of menstrual blood.

The defensive reactions on the part of the threatened organ or viscus leads to the formation of dense, organized adhesions, or even to marked thickening of the wall of the rectum or bladder in the effort to resist perforation.

Adenomyomatous cysts are, as a rule, relatively small, but are nevertheless capable of enormous damage in the pelvis if neglected, owing to their ceaseless effort to find an outlet through perforation for the pent-up menstrual contents.

Adenomyoma occurs only in the female, and in more or less close proximity to the genital tract, or more specifically, to the course of the embryonic Muellerian duct. Within these limits, however, it has a surprisingly varied distribution. Though most often involving the uterine wall, it is not uncommon in the ovary, Fallopian tube, broad ligament, and round ligament. Adenomyoma of the recto-vaginal septum has been the subject of numerous special contributions, among which those of Cullen are most conspicuous. The tumors of this region form an interesting and important group. More rarely, they have been found at the external or pubic end of the round ligament, at the umbilicus, in the vermiform appendix, in the wall of the sigmoid and rectum, in the lower ileum, and in the utero-sacral ligament.

Wherever located, or however remote from the uterine canal, there is invariably the same sequence during the menstrual cycle, of engorgement, blood-effusion, tension, and pain, followed by gradual absorption. The pain then subsides, tension is relaxed, and the tumor becomes softer and more difficult to outline on examination.

Adenomyoma is essentially benign in nature, but the erosive property to the mature cystic type of tumor is such that it may acquire the character of semi-malignancy, in a vital or clinical sense, owing to its destructive action on important contiguous organs. In fact, certain advanced cases with perforation of the rectum, may become frankly inoperable. Under these circumstances, the depth and density of the organized adhesions, the obliteration of lines of cleavage, and the thickening and rigidity of the rectal wall, offer insuperable obstacles to intelligent operative effort.

The tendency to actual malignant degeneration, common to most pelvic tumors, is well marked in the case of adenomyoma, owing to the epithelial elements in its structure and to the constant irritation of its contents.

The characteristic symptom of adenomyoma is dysmenorrhœa, and many of the severest cases of this painful disorder that we meet with are due to this cause. It is well to bear this in mind in connection with every case of severe dysmenorrhœa that cannot be readily attributed to other causes.

Less characteristic, but fairly common in advanced cases, is irritability of the bladder. Actual cystitis may occur. I recall two cases with this troublesome complication associated with adenomyoma of the antero-lateral wall of the uterus, very adherent to the bladder but without perforation, both of which resisted all treatment until the growths were removed by hysterectomy.

With a tumor adherent to the rectal wall, tenesmus may be present, or dark blood may be passed at stool during menstruation. A closely adherent tumor may cause this symptom without actual perforation.

With reference to treatment, two resources are available—operation and radium. As to radium, the problem that presents itself in considering its use for the cure of adenomyoma is very different from that which pertains to its use in the case of fibromyoma. In fibromyoma in young women it is possible, by careful dosage, to do away with the tumor by means of radium and at the same time to conserve the menstrual function. Such is not the case with adenomyoma. Here we must use a dosage which will effectually put an end to menstrual life, if we elect to use radium at all. In view of the natural history of adenomyoma and the way its deleterious effects are produced, it is clear that its pathologic changes and painful symptoms are entirely dependent upon the menstrual cycle, and to effect a cure by radium we must expect to destroy this function entirely. For this reason I regard operation as the method of choice. The character of operation will depend upon the location of the tumor or cyst. There is reason to believe that many small cysts that are closely contiguous to the uterine canal, or in other words, submucous cystic adenomyomata, have been unwittingly relieved for a time by a simple D. and C., the curette breaking through the partition separating the cyst from the uterine canal. Some relief may be had for a time in such an event, but the symptoms are prone to return, owing to subsequent closure of the drainage vent. Adenomyoma of the recto-vaginal septum is treated by local excision from the vaginal side.

The growths which are limited to certain areas near the skin surface, as the umbilicus or pubic end of the round ligament, are handled by suitable local operation.

For the tumors or cysts involving the pelvic organs, a median laparotomy is done. If the growth is located in the adnexa, the ovary, tube, broad ligament, or round ligament, it is resected together with the affected organ. In the presence of tumors or cysts of the adnexa, it is important that careful search be made in the effort to locate any additional growth in the uterine wall, as adenomyoma is apt to be multiple. They are not always easy to detect when small and collapsed, even with the abdomen open. In advanced cases involving the uterine wall there will be no difficulty in locating the growth. Its position is apt to be marked by the densest kind of organized adhesions, which may obliterate the normal peritoneal spaces and lines of cleavage. Hence it may be necessary to separate the adherent organs by actual dissection. The most troublesome adhesions are to be found between the uterus and rectum, or uterus and bladder, depending upon which uterine surface is affected.

For adenomyoma of the uterine wall, complete hysterectomy is the operation of choice, the resection including both tubes but leaving one or both ovaries, or part of an ovary. If the difficulty of complete hysterectomy is considerable owing to infiltration of the pelvic tissues, the supra-vaginal operation may be done. If the disease is so extensive as to require removal of both ovaries as well as the uterus, the operative hazard is also apt to be serious, and in this event it would seem to be better surgery to abandon the operation entirely and resort to radium after convalescence. The artificial menopause would result in either case, but the risk would be considerable in the one while negligible in the other. The menopause, whether natural or artificial, will put a stop to the functional activity of adenomyomatous glands, and thereby check further pathologic change as well as bring symptomatic relief. The point I wish to make is, not that double oophorectomy will add anything to the operative risk attending hysterectomy alone, but that such widespread invasion of the pelvis is not met with except in advanced cases with thickening and rigidity of the tissues and difficult adhesions, hence the danger of radical resection is materially increased. Furthermore, since the artificial menopause would result, and since this fur-



nished the main argument against radium in the first place, it would seem to be the part of good judgement to choose induction of the menopause with safety by means of radium, rather than the more hazardous attainment of the same end by a surgical procedure difficult and severe at best. The glandular tissue of adenomyoma becomes functionally inert after the menopause, whether normal or artificial, and as already pointed out, this is followed by more or less complete symptomatic relief, with cessation of progressive pathologic change.

This phase of the operative problem is gone into because of the frequency of reported cases wherein the operator has found it advisable to remove ovaries as well as uterus because of extensive disease. Personally, I believe the complete removal of both ovaries with the uterus will rarely be necessary. A very small layer of ovarian stroma may be left at the attached border with comparative safety even though the ovary is extensively diseased, and this will suffice to forestall the menopause. Recurrence in this area is unlikely, owing to the tendency of adenomyomatous cysts of the ovary to grow away from the hilum and towards the free border, as pointed out by Sampson. To summarize, hysterectomy is to be preferred in case of adenomyoma of the uterine wall, and this can be carried out in all but exceptional cases without the necessity of inducing the menopause, even though the ovaries may be involved. In inoperable cases, or where removal of both ovaries with the uterus seems unavoidable, radium remains as a safe recourse for attaining symptomatic relief and functional quiescence through the induction of the artificial menopause.

In case of very small early growth, favorably located on the free surface of the uterus, local resection may be considered, with due regard to the probability of recurrence. This local excision, to which the term adenomyomectomy might apply, is comparable to the similar operation of myomectomy for small mural fibroids, but with this essential difference, that whereas in myomectomy for fibroid it is desirable to avoid entering the uterine cavity if possible, in excising adenomyomatous tissue the reverse would be true. In mural adenomyoma it is generally possible, as shown by Cullen, to trace a histologic continuity between the tumor glands and the uterine mucosa. This fact makes it clear that if local excision, or adenomyomectomy, is to be under-

taken, it is essential that a block of tissue be removed including the entire thickness of the uterine wall. With this condition imposed, the field of usefulness of local excision as applied to the uterus becomes correspondingly restricted.

After radical removal of all aberrant gland tissue by whatever method may be employed, hysterectomy, adenomyomectomy, or local resections of the adnexa or other parts, the prospect for permanent cure is altogether good. There is no tendency to metastasis or local recurrence.

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## DRINKING WATER WITH MEALS A POTENTIAL AID TO DIGESTION

GEORGE M. NILES, M.D.,  
Atlanta.

Water, the cup that cheers but not inebriates, the universal solvent, has claimed attention from earliest antiquity. As a therapeutic agent it has proved most efficacious, and since Naaman, the Syrian, was healed of his leprosy by bathing in the river Jordan, even to the present moment, there has been no lack of earnest adherents to the various methods of hydrotherapy.

In this paper I desire to discuss the much misunderstood subject of drinking water with meals, for with a few exceptions, but scant attention has been accorded it by writers on digestive problems, who allude to it in a careless and perfunctory manner.

There is a wide-spread idea (happily being now somewhat abandoned) that the habit of imbibing water or any other fluid as food is being taken, is harmful to digestion; that it dilutes and weakens the digestive juices, thereby interfering with the satisfactory functioning of the stomach and the orderly progress of digestion. The idea is by no means confined to the laity, for the medical profession almost unanimously advise strongly against the drinking of large amounts of water at meal time, and as a matter of routine prohibits the practice. I have now at hand the printed diet list of a prominent stomach specialist, bearing the injunction—"Do not take more than one and one-half glasses of fluid with any meal."

This wholesale indictment is radically wrong, it is based on erroneous physiologic conclusions, and perpetuated by tradition. As a shining instance, however, of one who would cast aside tradition, and utter words almost prophetic, let me quote the late Prof. Austin Flint, who, in a lecture delivered when the writer was a student

years ago, said, "Gentlemen, *theoretically*, the ingestion of much water would dilute the gastric juice, and impair the digestion, but *practically* this does not seem to be the case."

The older works on physiology taught that the contents of the stomach were kept in a gentle rotary movement, so as to become more uniformly mixed; that each portion of the stomach contents was thoroughly "churned", as it were, so that the gastric juice would quickly and effectively permeate the whole mass; that the salivary digestion of starchy foods ceased as soon as the stomach was reached; and that the musculature of the stomach had a decided triturating power.

In recent years the subject has been investigated with great care by means of x-rays, on the excised stomach, and by means of tambours introduced into that viscus to measure the pressure changes. These researches all unite in emphasizing one fundamental fact—mainly, that the fundic end of the stomach is not actively concerned in its movements, but serves rather as a reservoir for retaining the bulk of the food, allowing the ptyalin more time to continue its work, and by the normal tone existing in the fundus, as well as in the whole organ, to gently force its contents down into the main body and pyloric region of the stomach, as is required by orderly digestive progress. Furthermore, the observations of Cannon, Grutzner and Pavlov indicate that the successive portions of a meal as taken, instead of being speedily mixed, are arranged in definite strata, while the succeeding portions are arranged regularly in the interior in a concentric fashion. This is readily understood, when one recalls that the healthy stomach has never any empty space within; its cavity is only as large as its contents, so that the first portion of the food eaten entirely fills it, and successive portions, finding the wall layer occupied, are received into the interior. The ingestion of much liquid into an atonic stomach would, therefore, interfere somewhat with this stratification, but not so in a stomach of normal tone.

As to the order in which the different elements are evacuated from the stomach, it has been demonstrated by Cannon and Pavlov that, when liquid food alone is taken, it can be forced into the duodenum in a few minutes, and that when a mixed meal is taken, the liquid part is first expelled, then the major part of the carbohydrates, then the major part of the proteins, and last the fats. Fats remain long in the stomach when taken alone, and when combined with other food-

stuffs markedly delay their exit through the pylorus. On account of the stratification of the food as it occupies the stomach, that taken first has the position of advantage. If it is carbohydrate, it is promptly ejected into the intestine, but if it is protein or fat, the passage of the carbohydrate will be delayed. Water, though, finds a ready exit when taken at any stage of the meal.

There are a few conditions, nevertheless, in which much water with meals is contraindicated: In gastroparesis, on account of the weight of the water, which drags heavily on the already relaxed and inefficient gastric supports; in dilated or atonic stomachs—those where splashing sounds may be easily elicited, because there is not enough tone to the musculature to promptly evacuate the contents, and an excess of water, added to a meal would promote further atony and dilation; in patients with weak hearts or uncompensated valvular lesions. Occasionally, where there is a marked tendency to colic, or spasm of the pylorus, water should be drunk moderately with meals. I might mention also that copious draughts of ice-cold water, gulped down during fatigue or profuse perspiration are both unhygienic and dangerous.

On the other hand I find that a large proportion of patients coming under my notice, who suffer from poor nutrition, constipation, intestinal toxemia, and numerous other states of disordered digestion, are those who drink no water with meals, or if at all, very sparingly.

Desiring some additional data on this interesting but neglected subject, several years ago I enlisted the aid of sixteen young men, sophomore medical students, who cheerfully agreed to submit for eight days to a series of experiments along this line.

These young men were of healthy physique, and, with one exception, reported daily evacuation of the bowels. Their ages ranged from twenty to thirty-three, their weights from 124 to 168 pounds. All had normal hearts, lungs, and kidneys, and their stomachs were of proper size and correct position. Each one was in the habit of drinking one or two—not more—glasses of water or fluids with each meal.

Eight of the young men were instructed to drink no water or other fluid with meals, and between meals to drink no more than demanded by actual thirst. The other eight were instructed to drink four glasses, or one quart of water, with each meal, and between meals to drink it or not as was desired.

These young men were carefully watched, regularly weighed, and each symptom recorded as it appeared. Omitting the detailed reports, I summarize the results as follows:

Of the eight who drank no water, all lost in weight—from 8 ounces to 2 pounds—with one exception. This exception remained at exactly the same weight, and it might be mentioned that this young man was holding a position as railway mail clerk in addition to his regular college work, and that he was so accustomed to irregular habits that shutting off his water did not affect him like the others. In addition to the loss of weight, each one complained of headache, and more or less constipation. Only their loyalty made them hold out to the end of the term of days, and they all seemed glad to return to their accustomed allowance of water.

The eight who drank four glasses at each meal fared much better. One of them said that four glasses rather distended his stomach, but did not cause any marked discomfort. Of these eight, all gained weight—from 4 ounces to 2½ pounds, except one whose weight remained the same. Not one reported headache, constipation, nor any form of digestive discomfort, and the single one who was constipated at the beginning of the experiment, found his bowels more regular in five days. Not one of the eight suffered a single qualm of indigestion.

The presence of an abundance of water during the busy period of digestion is as necessary in efficient "bodily housekeeping" as it is to the housewife in her domestic housekeeping.

This error concerning the influence of water-drinking at meals is widespread and firmly entrenched, and should be combatted by every earnest physician.

As the first principle of hydrotherapy, therefore, each patient should be instructed to drink copious amounts of water with each meal, unless it is positively and logically contraindicated. With this injunction should be given an explanation of the reason, as well as an assurance that the water will not be harmful, otherwise some disciple of the ancient traditions against water will frighten the patient by dire prophecies of the danger that will ensue, so that the liberal amount will not be drunk, or, if it is, will be taken with a mental attitude of apprehension.

I trust that this paper will teach its lesson, and carry a worth-while message.

## INDIVIDUAL DELINQUENCY

G. H. BENTON, M.D.,  
Miami.

Often the medical man not especially trained in psychiatric medicine is called upon to express his opinion as to the qualities, quantities and often therapy in the individual delinquent, either in the law court or in the family circle. The exciting cause offer a condition which has precipitated a great deal of horror and consequently disappointment which, however, may be more or less expected on the part of the closer relatives. There are certain usually recognizable manifestations that occur in the individual delinquent which are sometimes recognized, often overlooked, more frequently are so masked that they are misinterpreted or they are visible but excused by the family, or friends, often the teachers; but never by the disinterested public at large. One of the primary personal equations is a gross selfishness which demonstrates the absence of certain acceptable qualities in the inherent gregarious instinct. This is accompanied by a lack of adequate inhibition so often demonstrated by the tendency to appropriate the properties of others without comprehension and a more or less total disregard for the rights or the privileges of others and this without any recognition of the value of the damage to or loss of or inconvenience of others. These individuals have no idea of the value of an anti-social act; although they know right from wrong they have no apperception, consequently no judgment nor way of arriving at the conclusion of the relative value of things. Selfishness in the delinquent is expressed by lack of filial love or any comprehension of duty towards the parents or guardians, teachers, or anyone having authority over them; complete absence of loyalty, diminution or loss of recognition of the value of family ties and often lacks respect for parents, also lack of appreciation for benefits received or offered; absence of pride though often abnormal presentation of generosity; absolute lack of gratitude, lack of inhibition, consequent emotional instability, all of which constitute an inadequate personality. When one's imagination is of such a quality or quantity as to exclude the fear of consequences, they are potentially if not actually delinquents. The moral sense is the most vul-



nerable quality of the mind and the ability to acquire adequate ethical standards is a special quality representing purely a personal equation, not necessarily dependent on any physical quality or quantity of the intellectual capacity. The lack of the ability to acquire ethical ideas and standards appears to be an inherent defect and perhaps bears the same relation of mental capacities as other factors, for instance: one individual, by lack of opportunity or industry or ability, may be unable to acquire any knowledge or efficiency in mathematics yet he becomes a great financier; one individual has no capacity for music, perhaps being entirely unable to carry a tune, yet other qualities of the intellectual capacity excel in one or several directions. The individual who demonstrates early moral deficiencies, with or without criminal tendencies, signifies an inherent mental defect of such nature and quality or quantity that he fails to adjust, which may or may not be remedied by special training and education, or re-education, under individual guidance by especially qualified individual or individuals in more or less constant association, who are capable of attracting and holding the attention of the delinquent; hence, the rehabilitation of this class of individual is more or less of a special nature. Each delinquent varies equally in proportion to his inherent defect plus his environmental requirements. Consequently penal institutions and punitive measures usually fail in their efforts in these cases by virtue of their necessary character and especially environmental qualities.

Imagination is an intellectual process. Imagination may be defined as "The use which the reason makes of the material world," (Standard Dictionary). Imagination, however, is often misunderstood and misinterpreted as the cause of reaction to a multiplicity of autonomic states. The individual delinquent may be a mental deviate of the most varied and various degrees or he may be *apparently* normal. Consequently his mental capacity may be good, bad or indifferent, hypo- or hyper-normal intellectual acuity representing all degrees from the imbecilic state to the genius and regardless of the variations of degree but lacking the quality of sagacity which involves apperception and consequently judgment, he is bound to fail in his personal and social adjustments.

## OVARIAN TUMORS IN CHILDHOOD. WITH REPORT OF A LARGE OVARIAN CYST WITH TWISTED PEDICLE, SIM- ULATING PREGNANCY, IN A CHILD OF TEN YEARS.\*

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Ovarian tumors occur not uncommonly in childhood, being rare in infancy, however, but more frequent as puberty approaches. Diseases of the internal organs, the uterus, uterine tubes, and ovaries for the most part arise during the period of sexual activity, and the cases occurring later in life are as a rule due to the future development of diseases which have already started in earlier life. While this is true in general, a careful search of the literature shows that pelvic affections during childhood are far more frequent occurrence than is usually supposed. In some instances conditions first observed after puberty are actually due to disease existing earlier in childhood, but not attracting attention until the organs are called into active use.

Almost all forms of diseases of the tubes and ovaries found in adults have been observed during childhood; certain pathological conditions being relatively more frequent at one period than at another; thus in children under three years, ovarian tumors have been found principally, and these dermoids or sarcomata.

Cystic ovaries are frequently observed in infants and have been described by De Sinety and others. According to Kissel's investigations these cases of cystic follicles are rare in children after the first year, and they should not be confounded with the adenocystomata, which make up a large proportion of the ovarian tumors of later childhood and adult life.

While ovarian tumors may be found in the earliest years of childhood, they become more frequent in girls approaching puberty. Half of the tumors at this period belong to the cystomata. A few carcinomata have been described in older children, and inflammatory diseases and tuberculosis also occur.

### DIAGNOSIS

The diagnosis of diseases of the tubes and ovaries in children may usually be made without difficulty. The diagnostic signs are the same as those in adults, with the notable exception of the differences in the topographical relations. Owing to the relative smallness of the abdominal cavity,

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a tumor will begin to encroach upon the vital space in a child when it has reached a size which in the adult would scarcely be noticeable. In this way an ovarian tumor the size of a child's head, lying in the abdomen, stands so high and occupies so much space that it may at first slightly resemble a tumor either of the liver or of the kidney. Owing also to the smallness of the pelvic space and the straightness of the canal, the tumor is extruded earlier into the abdominal cavity than is usual in the adult.

The most complete article on the subject of ovarian tumors in childhood is written by Howard Kelly and appears in "Keating's Cyclopaedia of Diseases of Childhood." He collected reports of 126 cases of ovarian tumors in children; 55 were cysts, 47 dermoids and 24 were solid. Of fifty-five cystic operations upon children, four died, a mortality of  $7\frac{1}{3}$  per cent. The youngest case reported occurred in an infant four months old; the next ones in point of age were three and four years, respectively.

#### OVARIAN TUMORS

The ovarian tumors occurring in children may be classified as follows:

Cystic tumors.....	{	Adenocystomata
		Unilocular
		Dermoid cysts
Solid tumors.....	{	Sarcomata
		Carcinomata

Adenocystomata, or multilocular cysts, the classical ovarian tumors, form the most numerous group of ovarian growths occurring in childhood, and are in all respects similar to the ovarian cysts found in adults. Probably the largest cyst observed during childhood is the case successfully operated on by W. W. Keen of Philadelphia. The patient, fifteen years of age, for two years had noticed an increasing abdominal enlargement, accompanied by pain in the left side. She had been tapped twice, eighty-four pounds of fluid being removed. At the time of the operation the abdomen was greatly distended, measuring forty-nine centimeters in circumference, and the superficial veins were prominent. Extirpation was affected without difficulty, as there were but few adhesions. The patient made a good recovery. The tumor was a multilocular ovarian cyst weighing one hundred and eleven pounds.

#### DERMOID CYSTS AND TERATOMATA

These tumors are for the most part of medium or small size, rarely attaining large dimensions. They are sometimes monocystic, at other times multilocular, in some instances the dermoid elements are present in only one loculus, while the remaining portion of the tumor is identical with the ordinary adenocystomata.

A strong confirmatory evidence of the origin of dermoids from misplaced embryonic tissue is the frequency with which they are found in children and the comparatively early period of life at which they are observed in adults. The average age of all the patients operated on at the Johns Hopkins Hospital for the extirpation of dermoid cysts was only twenty-six years. Of the ovarian tumors found in children, one-third, a high percentage, contained dermoid elements. Tumors of this nature are in some instances congenital.

Dermoids are of slow growth, and often do not manifest their presence until adult life, the normal functions of the ovary remaining undisturbed. This is readily understood from their histological structure, as the majority of these tumors contain developing and mature follicles, especially numerous in the vicinity of the hilum. Many of them also contain endo-, ecto- and mesoblastic structures.

#### SOLID TUMORS

*Sarcomata*—The activity of the ovarian stroma in early life suggest an explanation of the relatively frequent occurrence of sarcoma of the ovary in children. Congenital tumors often belong to this group, and frequently their histological elements bear a striking resemblance to embryonic ovarian stroma. In their histological structure, sarcomata occurring in infancy and childhood comprise several varieties; by far the greatest number, however, consist of small round cells, a few belong to the spindle-celled variety; one was described as a lymphangioma, another as an endothelioma, and Gage describes his case as a fibrosarcoma.

*Carcinoma*—There are on record six cases of carcinoma of the ovary occurring in children, a large number considering the rarity of carcinomata in general in early life. Carcinoma occurs somewhat later than sarcoma. Redner operated on a child of nine years for an ovarian tumor which proved to be a carcinoma. Extirpation was without difficulty, as there were no adhe-

sions, and the child promptly recovered from the operation. One year later, however, she died from recurrence.

#### REPORT OF CASE

The patient, Ruth C. of Moultrie, Ga., was taken with severe cramp-like pains in abdomen during the night of June 20, 1917. The family physician was called, and after observing the patient for about two hours, he had the child's father call me. Upon my arrival the doctor stated that he had a very unusual case that he wished me to see—a girl ten years of age, who had never menstruated, but who from all appearance was seven or eight months pregnant and in labor.

The following history was obtained: She was a normal, well-developed girl just a few days past her tenth birthday, had never menstruated, had always been in the best of health and this was the first time it had ever been necessary to call a physician to attend her. The patient's mother had observed nothing unusual with the girl until she was taken with pains during the night.

On physical examination, I found a well-developed girl for her age; head and neck normal, chest negative, extremities normal. Blood-pressure 115-70. The abdomen was large, prominent, and projecting forward. There was definite fluid fluctuation and there was a flat note to percussion. The fluid was apparently encysted. The entire mass could be distinctly felt, was hard and firm and felt like a uterus at full term; there was no irregularity in outline. On auscultation no souffle or foetal heart sound heard. Vaginal examination not made as the hymen was intact.

Patient was taken to hospital and an immediate laparotomy performed. A large median incision was made, the tumor which was dark blue in color, was delivered through opening and found to be a right ovarian cyst with twisted pedicle containing one gallon of straw-colored fluid and some clotted blood. The tumor was removed without difficulty and the wound closed without drainage. The patient made an uneventful recovery, going home on the fourteenth day. Has had no further trouble. Married at age of fifteen and was a mother at sixteen, normal pregnancy and delivery.

#### MYOCARDIAL DYSFUNCTION\*

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Unless a valvular heart lesion is observed, the most of us are prone to disregard myocardial changes, whereas among heart cases, valvular lesions are relatively few.

Myocardial intoxication and degeneration divides itself into three stages, namely: Acute intoxication with response, intoxication and degeneration with impaired response, degeneration without response. It manifests itself by dysfunction of automatic rhythmicity, contractility, conductivity, irritability and tonicity, giving progressive objective and subjective symptoms grossly indicative of myocardial pathology from the very early finding of myocardial hypertonicity with from none or an occasional transitory decompensatory symptom of inspiration, to the vague sensation of precordial oppression of a few days' duration of the first stage.

Whereas, the findings of the second stage are more pronounced with one or more symptoms of early or advanced myocardial degeneration as, general asthenia, impaired digestion and assimilation, nausea, vomiting, epigastric pain, sensation of costal constriction, dyspnea at night, or on exercise (often asthmatic in type) dizziness, frequent fainting attacks on sudden change of position, anginal pains, paroxysmal or persistent tachycardia, accentuated sinus arrhythmia, premature contractions, missed beats, auricular flutter, alternating pulse, intermittent or persistent heart block, edema, cough, general moist rales, dilatation murmurs, cyanosis and increased pulse pressure. Any of these signs and symptoms may be disregarded early by the patient, who considers the subjective symptoms but part of the decline of the glands or other causes, or minimized by the physician as the results of other conditions, especially those referable to digestion, rather than of suspected cardiovascular origin, which in turn terminate in the third stage with augmentation of symptoms or sudden decompensation, marked drop in blood and pulse pressure and if unrelieved ending in a state of ventricular flutter, or complicated by anasarca, pulmonary and renal congestion with uremic symptoms.

From observation of our service, we consider all cases to be traceable to intoxication, divisible

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into endo- and exo-toxins. Of the former, focal sepsis predominates, the foci existing in order of prevalence in the intestine, tonsil, teeth, kidney, gallbladder and appendix, certain diseases of focal origin as diphtheria, scarlet fever and acute septic polyarthritis and in blood stream infections of syphilis and typhoid. To these may be added metabolic toxins created by irregular habits and diet. The common exogenous toxin is alcohol, especially of impure alcoholic beverages concurrent to so-called prohibition, with minor mention of tobacco, caffeine and lead.

And further, because of the immediate association of the parts of the cardiovascular renal system, we believe that all kidneys are damaged in cases showing cardiovascular disease, the degree of which is dependent upon the nature and duration of the poison, and that acute nephritic congestion, secondary to myocardial decompensation, is responsible for many so-called cases of uremia.

The degree of myocardial involvement may be estimated by: the nature of the heart sounds noting the deviation of intensity and duration; observation of exercise as to reaction and without distress as pain, dyspnoea and cyanosis; effect of an increased pulse rate on the size of the heart, for the size decreases in health and dilates with disease; the amount of dilatation present, noted by percussion, dilatation murmurs and the fluoro-scope; blood pressure readings, and the electro-cardiograph.

Because of the skill and expense connected with the use of the electro-cardiograph, the pulse pressure is probably of the greatest prognostic

significance to the greatest number of us, of findings secured by mechanical means, because of simplicity and warrants a brief review of interpretation.

Pulse pressure, which represents the relationship between force and relaxation, may be abnormally high or low irrespective of the position of the mercury column on the scale, and it has been observed that patients with unusual blood pressure readings, but with a normal pulse pressure show but few symptoms and respond to treatment favorably.

Early after intoxication, pulse pressure is decreased with a slight increase in systolic pressure, indicating a hypertonicity of the myocardium. With the beginning of degeneration pulse pressure is increased due to the loss of tone of the cardiovascular system with lessened diastolic response, and an increased compensatory ventricular contraction which apparently consumes reserve energy with a counter maximum inertia, and according to the invincible physical law that "to every action there is an equal and contrary reaction" kinetic energy becomes exhausted by persistent demand and systolic, diastolic and pulse pressures decrease as cellular degeneration and myocardial decompensation advances.

In conclusion, as the careful automobile owner submits his car to examination and early elimination of trouble by a skilled mechanic, people should be encouraged to present themselves for periodic examination and we physicians must not be unmindful of the early symptoms of disease and eliminate the focus before permanent damage is done.

# Looking Backward Over Fifty Years of Health Work in Florida

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The march of growth of the state in various ways of rapid development commenced from this period, which may be said to be the first mile-post planted on this highway of state development. By this act a confidence was established and firmly restored in the ability of the constituted authorities to control what were heretofore thought to have been unfavorable conditions because of nearness to tropical countries from which dangerously contagious diseases to life and health were frequently brought by marine transportation. Confidence reaffirmed in health conditions in the state, immigration from other states, which had been continuously invited, immediately commenced to come to Florida, both in visitors and permanent settlers, convincing those who came that the possibilities of wealth-producing was greater in Florida than in any other state of the Union. Not only in a wonderfully salubrious climate of God-giving health would this wealth be found, but from the soil and under the soil nature had bountifully offered opportunities to all who may come to find. It is quite possible that unless a great calamity, such as the yellow fever epidemic of 1888, had not occurred, the mandate of the State Constitution would never have been obeyed for a long period of time, because to some there did not seem to exist a necessity for an increase in expenses in the state government which a new bureau would require. It sometimes takes a great catastrophe to awaken the people to the necessity of speedy action in methods of defense against disease, as well as against invasion by arms from a foreign power, and it is equally fortunate that when those occasions do arise that there is a man provided by the Great Almighty, who has the vision to sight the danger of delay, and who has the courage of his convictions to act in spite of opposition of friends or the adverse criticism of enemies. Such a man was the late Governor, Francis P. Fleming. A man of untarnished character, fearless to act, when he felt that he was right, and with the courage of that conviction, did not

hesitate in what he conceived to be his duty. The people of Florida can never honor too highly the memory of Governor Fleming nor be too grateful to him. When the Hall of Fame shall be established in the state capitol at Tallahassee some day for the distinguished sons of Florida, the name of Francis P. Fleming will stand forth in letters of gold, "Of whom the love of God had blessed, he led the rest," because he loved his fellow men.

Although there was no central health governing body in the state prior to 1889, yet the Legislature of previous years had created county boards of health, and granted authority to impose a maritime quarantine when necessary to prevent any introduction of dangerously communicative contagious diseases from foreign ports. Accordingly, the seaport counties organized county boards of health, the members of which were appointed by the Governor generally on recommendation of the Democratic Executive Committee of each county. More often than not, these appointments which carried no salary or other compensation were of a political nature, or from personal friendship of the county committee, and not for fitness or a special knowledge or experience in maritime sanitation. Dr. Jerome Cochran, the State Health Officer of Alabama, stated at a conference of health officials of the Southern States, held in Montgomery in the late winter of 1888, after the epidemic of yellow fever in Jacksonville, that ninety-five per cent of all epidemics of yellow fever which had occurred in the Gulf States for the past thirty years had been introduced from Cuba, principally from Havana. There is no doubt but that his conclusions reached at that time were correct. Therefore, for the first half of the past fifty years, more attention was paid to preventing yellow fever and other contagious disease being introduced into Florida by shipping than was devoted to the study of civic, rural or individual hygiene and sanitation. It is mentioned in one of the bulletins of the National Board of Health, a Federal

organization which was created by Congress and functioned from 1878 to 1883, that the Florida Legislature of 1852 authorized the seaboard cities and counties to establish maritime quarantines against vessels arriving from foreign ports which were known to be infected with contagious diseases. Dr. R. B. Hargis writes in one of the bulletins of the National Board of Health an interesting account of the prevalence and course of an epidemic of yellow fever in Pensacola, Florida, at the navy yard in 1852, and speaks of quarantining of several infected vessels arriving from Havana, by which the fever was introduced. The narrative is exceedingly interesting as an epidemiological study when comparing the deductions of Dr. Hargis as to the cause and spread of the fever then, with the knowledge now had of the methods of transmission of the disease. The Pensacola quarantine station seems to have been particularly lucky in having aid from the National Board of Health during the five years that the Federal Board functioned, from 1878 to June, 1883. It is not learned that any other of the quarantine stations in Florida were then so fortunate. In the report of the Federal Board for a period ending June 30, 1883, the following items of donation of assistance are mentioned: "Aid to Pensacola, Florida, year ending June 30, 1880, \$3,006.28; year ending June 30, 1881, \$4,444.88; year ending June 30, 1883, \$6,886.85." It is not known that any other quarantine station received Federal aid until 1901, when under an Act of the Legislature of that year, authority was granted the State Board of Health to sell to the United States Treasury Department, for management by the United States Public Health Service, all quarantine stations owned and operated by the State Board of Health. Late in the summer of that year an appraisalment of these properties was made, jointly by officers of the United States Public Health service and the State Board of Health, and a transfer was effected on August 1st of that year.

Unfortunately the money obtained from the sale of the quarantine stations was turned into the general treasury of the state, by direction of the Board of State Institutions, as recommended by the Governor, Hon. W. S. Jennings, although the stations had been operated not through taxation of the people, but from fees received from shipping in connection with maritime sanitation which the State Board had operated from its organization. The transfer of quarantine authority to the Federal Government in no wise

lessened the responsibility of protection to the citizens of the state in guarding the state from invasion of contagious disease generally conveyed by vessels and shipping, but rather added a greater cooperation of defensive methods from the Federal as well as the State Health Authorities. Under an arrangement sanctioned by the Treasury Department of the Government, the state quarantine officials were accepted into Federal service as civil service employees in the Public Health Service, and clothed at the quarantine stations with full authority of the government to enforce the Federal quarantine regulations. By this transfer the service then to commerce was free, and it is worthy to note here that notwithstanding the protest made heretofore by the United States Public Health Service against imposing of fees by the state health authorities on foreign vessels entering the ports of the state during the quarantine season each year from May to November, is now being imposed by the United States Government and is collected through the custom house at each port. This regulation is, however, uniform throughout the United States.

In mentioning the relation of the Federal Government with the State Board of Health, in co-operative conduction of maritime health matters, a phase of management, which the State Board of Health has just cause to take pride in, occurred in 1893, when the people of the United States were being greatly disturbed by the appearance of cholera in European ports. A vigilant watch was being exercised by inspectors of the Public Health Service at ports of large departure of passengers and emigrants of nondescript character, that cholera might not be introduced by them through maritime communication into the United States. The Congress of the United States passed an Act providing for a national quarantine supervision by the United States Treasury Department, acting through the United States Public Health Service (then the Marine Hospital Service), by which all shipping leaving foreign ports destined for the United States and carrying passengers therefrom should be inspected thoroughly before departure, the health of passengers and crew to be certified to, and vessel required to obtain a bill of health from the medical attache of the United States consulate at the port of departure, setting forth a freedom of disease among passengers and crew. A pratique certificate signed in consequence therefore carried a permit to enter any port of the United



States, provided no sickness existed on voyage among passengers or crew at date of arrival at any port of the United States. Failure to have this required certificate, the vessel with passengers and crew would be detained in quarantine until such time had passed, insuring safety. It was necessary that this new organization of the government should have rules and regulations to operate under, and consequently the Surgeon-General of the Marine Hospital Service, now the Public Health Service, called together the health officers of the seaboard cities and states to confer and assist in framing such regulations and rules for a national quarantine system which would not be burdensome to any portion of the country, or unreasonable in exactions, but yet adequately and comprehensive to thoroughly protect the citizens of the United States against introduction of dangerously contagious diseases. Surgeon-General Wyman presided at this conference, with Surgeon Henry R. Carter assisting, and the actual genius of the rules to be formulated. Each phase of quarantine management was gone over in a careful and painstaking manner, leaving no point untouched which might bear on the subject of disease prevention by maritime sanitation at the ports of entry of the United States. Surgeon Henry R. Carter of the Public Health Service, then the Marine Hospital Service, was, as has been mentioned, the guiding hand in selection and adoption of rules and regulations which should be those of the national quarantine. It was gratifying, however, to discover that the principles of maritime sanitation of the State Board of Health of Florida, framed and adopted in 1889, were approved of and had been grasped by the national board's Committee on Rules and Regulations, and with but very slight change in verbiage, had been made a part and portion of the national quarantine law, especially as regards the treatment of passengers and shipping from yellow fever-infected countries. The quarantine regulations of the State Board of Health of Florida in 1889, when compared with the quarantine rules and regulations of the United States Quarantine Board constructed in 1893, will bear out the above statement.

An incident of noteworthy mention in the past health history of the state occurred just following the termination of the Spanish-American War of 1898. A large number of marines were quartered in an unoccupied cigar factory near the navy yard reservation at Key West during

the summer of 1898. An undefinable fever of short duration appeared amongst them, resembling in some respects yellow fever, but lacking in most essential diagnostic points. A young assistant surgeon of the navy, stationed at the navy yard, who had lately been assigned to duty at Key West, because of nativity at New Orleans, immediately assumed a positive acquaintance of the disease and proclaimed it yellow fever. Nor was the young surgeon alone in his views, for his seeming earnestness of diagnostic ability persuaded several of the local physicians to agree with him. The State Board of Health's representative at once went to Key West, but was not permitted to see the sick men unless clothed in a rubber coat and cap. As the month was August, it can be appreciated the sweltering discomfort experienced in making a thorough examination of a hundred sick men. The State Board of Health's representative declared the fever was not yellow fever, although withholding a positive diagnosis of actual sickness for several days, but leaning in his opinion to dengue. The absence of the characteristic rash in the cases first seen being the only lacking point in a positive diagnosis of dengue. To those who are acquainted with yellow fever, it will be appreciated that in many respects the invasion of "break-bone fever" is not unlike that of yellow fever, except—and here are three important differences: Yellow fever almost always—of course there are exceptions—commences with a chill occurring between midnight and daybreak. Malaria and dengue select daylight for its initial chill. The suffering from vicarious pains is greater in dengue than in yellow fever, and a rash resembling measles in character of eruption appears on the third day in dengue, or in some instances is delayed to a later period of the sickness. The patient in yellow fever is slow to recover strength and convalescence is prolonged. In dengue recovery is rapid and there is no appreciable loss of strength for more than eight or ten days. Pardon this digression, because it was necessary to emphasize the stand that the State Board of Health took in regard to this outbreak. The announcement of yellow fever among the Marines by the naval surgeon caused a stampede, not only in great consternation among the fleet anchored in the harbor, for the whole of the navy was in port awaiting future disposition of stations since the war had ended, but likewise among the merchants of the place, who because of the demand

for food supplies, such as potatoes, onions and other vegetables, had ordered from elsewhere large quantities to supply the requisition made upon them. Immediately upon the report of yellow fever at Key West, the vessels of the fleet were ordered to Northern stations, and consequently an enormous money loss was sustained by the merchants and others doing business with the vessels of the fleet. The State Board of Health remained firm and unchanged in its opinion as to the non-character of yellow fever, and waited patiently for the appearance of the rash, which was the only remaining symptom of dengue which was lacking. It is well remembered when the first case of rash was discovered, on a Sunday morning, in the person of a stranger. At once Dr. A. H. Glennan of the Public Health Service, afterwards himself a victim, who had been sent to Key West by the Bureau of Public Health to watch events, was summoned and shown the patient, who was beautifully covered with a fine measley rash, from head to foot, not excepting even the palms of the hand and soles of the feet. Later in the day a telegram was received from Dr. Geddings, the U. S. Public Health Officer in charge of a detention camp at Egmont Key, at the mouth of Tampa Bay on the West Coast of the state, that he had found a rash case in a refugee from Key West. The Public Health Service, as a matter of precaution awaiting the final determination of the prevalence at Key West, had previously established a detention camp for five days' stay of persons leaving Key West prior to being allowed further travel into the state or to points northward. The epidemic of dengue that summer at Key West was widespread; but it never was discovered from whence it came. Natives, who had yellow fever, Cubans likewise, negroes and persons in every walk of life, experienced the distressing malady, and it was estimated that there were over five thousand cases during the two months of its existence, but without a single fatality. It is not necessary to mention that but with one exception, who recanted, the local doctors and military medical men adhered to their first statement, notwithstanding the fact that it was shown them time and time again during that summer that the prevalent illness was nothing more nor less than mild break-bone fever. "The horse has been stated by them in the first instance to be fifteen feet high, and so it remained in height," in their opinion.

Another incident equally as interesting and important as also showing the value of a central health authority of the state in controlling conditions which if left to themselves to work out would have brought disaster and chaos by mismanagement, was when smallpox was discovered at Key West in the summer of 1896, in an adult negro, after it had been mistaken by two of the local physicians for chicken pox. The disease had gotten under considerable headway when discovered by the State Board of Health. At the time the statutes of the state and the regulations of the board compelled the board's care for every case of dangerously communicable contagious disease occurring in the state, both in maintenance by food, medical attention and isolation under guard, that the well might not come in contact with the sick. The cases multiplied so fast after discovery that permission was obtained from the President of the State Board of Health, then Hon. William B. Henderson of Tampa, to erect on the south side of the island of Key West, on land borrowed for the purpose, a suitable hospital building for races and sexes. When completed, furnished and ready for occupancy, the mayor of the city was requested to have the cases removed to the building. On his refusing to do so, he was informed that unless every case of smallpox, the location of which was designated, was removed by a certain hour—giving twelve hours to do so—the State Board of Health would withdraw all assistance in caring for these patients, and the city would be placed by the State Health Officer, who was clothed by statute with such management, under strict quarantine from the rest of the state. The Hon. H. L. Mitchell was then Governor of the state. He was communicated with by telegraph, and requested to obtain consent of the U. S. Navy Department and the United States Treasury Department to aid the state health authorities in perfecting a maritime quarantine from the rest of the state until such time as cases of small pox should cease to exist at Key West. The action of the State Executive was speedy, for the next morning Captain Sigbee of the United States battleship Maine, then lying in the harbor, called upon the state health officer, stating that he had been instructed by the Secretary of the Navy to report for such duty as might be desired. Just a simple request was made of Capt. Sigbee—that no vessel or person thereon should be permitted to leave the harbor of Key West without written permit from the



State Board of Health, stating that passengers and crew had been satisfactorily vaccinated. A proper vaccination being recognized as the only safeguard needed against contracting smallpox. The main entrance and outlet of the harbor was guarded by a motor launch from the battleship *Maine*, with a one-pound gun in the bow. An officer from the *Maine* was in charge of this launch which patrolled the outer harbor day and night. The upper harbor was under the supervision of the State Board of Health's launch; the channel leading from the harbor at this point was shallow and only with difficulty could very small craft pass out. The quarantine of the harbor was being conducted smoothly and without any friction with the sailing craft or steam vessels of the larger size, entering or departing from the port, until a fateful afternoon when a rumor was circulated that one of the Mallory Line of steamers was ashore just off the main ship channel from the gulf, coming from Galveston, Texas. Immediately there was a great commotion among the sail craft and a wrecking tug was soon in a state of preparation to go to the assistance of the supposed vessel in distress. The launch from the *Maine* was kept for an hour or more busy rounding up the small boats and sending those back into the harbor not having acquired permit for leaving. The owner of the tug had previously boasted that his vessel would not be stopped did occasion arise to leave the harbor, and neither would he procure the needed permit. The tug being faster than the government launch soon outdistanced the latter, nor would attention be paid to the warning from blank shots from the launch. However, it was evident that the deck officer of the *Maine* was keenly watching, and when the tug did not heed the warning from the launch a blank shot was sent from the *Maine*. This did not seem to disturb the progress of the launch; but when the tug did not stop, a shot was fired which dropped just ahead of the course of the tug. The effect was instantaneously marvelous. A "hard about" was executed, and with the parasitic sail craft following in the wake of the tug that had gotten by the *Maine's* launch, a speedy return was made to port. A "quick get to" the office of the State Health Officer was made to be vaccinated and procure a permit to leave. That shot from the *Maine* had a most potent effect in enforcement of quarantine regulations in after years, for it carried a message that the United States Government stood behind

the constituted authorities of a state in assisting in an enforcement of protection to life and health of the citizens of any community in the United States, when a request was made to give that help. Three years afterwards when yellow fever appeared in Key West, there was no friction nor unpleasant controversy in carrying out needful restrictions of travel, in protecting the rest of the state.

Another incident connected with a chronology of health supervision in the state of Florida for the past fifty years, is one that occurred during the legislative session of 1901. The State Health Officer at that time had obtained a leave of absence from the State Board of Health "without pay," and had been selected as a Representative from Monroe County in the lower House of the Legislature. He was unfortunately impressed, and as subsequent events proved, disappointedly, in thinking that his presence in the Legislature might assist in passing some needful health legislation. Smallpox in the upper border of the state in number of cases had been creating a great deal of annoyance to the State Board of Health, as the board was charged by law, or the law was so construed, to care for medically and by food all sick of smallpox which were reported. The southeastern part of Georgia was riddled, it might be said at that time, with cases of smallpox which the authorities of that state paid but little attention to, nor took precautions to prevent spreading. The prevalence was principally among the colored race, and the negroes passed from Georgia to Florida without hindrance and without the knowledge of the Florida authorities, which was not known until the disease appeared in the settlements along the border line; and this state of affairs was invited in many instances by the demand for labor in Florida. How to remedy this condition which was causing the State Board of Health worry and expense, although the disease in the most part was of a mild character, and not marked by fatalities. After election to the House of Representatives from Monroe County, the State Health Officer framed a bill to enact a compulsory vaccination; but the important feature of the bill was to prohibit and forbid operators of large industries, such as mill, turpentine and phosphate activities, employing labor before operators and laborers were successfully vaccinated. The bill was introduced simultaneously in the Senate and in the House. It passed the Senate with but little opposition, but in the



House a different fate met its introduction and final effort at passage. The old-time argument of "losing arms and legs from vaccination" was brought forth by the radical opponents, although no instances could be cited to prove the argument. It was always "some one had said so." The bitterest antagonist was an elderly Baptist minister from one of the mid-west counties, who worked himself up into such a fever of excitement and vituperation against all proponents of the measure that the State Health Officer, not wishing to witness a ruptured blood-vessel, and perhaps sudden death on the floor of the House, closed the argument. When the vote came the bill was lost by six votes—the number of absent members, who were friendly to the proposition. It was announced that vaccination was offered freely and without expense to everyone, man, woman, or child, who would avail themselves of its protection against smallpox, and it was explained, moreover, that the board frowned upon the practice of arm to arm vaccination; that is to say, the use of humanized virus, using only cowpox from healthy heifers, prepared under the most stringent and aseptic conditions of U. S. Government supervision. It was also spread broadcast through the state that no longer would guards be employed or except in very exceptional poverty-stricken cases would the board assume a responsibility for food, medical aid, or nursing, but that the public may be warned of danger, every house or premise having a case of smallpox would be placarded, stating that smallpox existed within and to *keep out*. Keep

out applied only to the non-successfully vaccinated. Very soon was accomplished what the bill proposed in the Legislature sought to bring about. Families in which smallpox existed were ostracized, both socially as well as in all other mingling, unless vaccination was adopted, and the fact certified to and made public. Thus it was that *public opinion* did afterwards what a legislative request backed by a citation of facts and figures, which could not be successfully contradicted, failed to do. It was a triumph of educational reasoning, actuated not alone by fear but by personal inconvenience and perhaps loss of employment if not duly observed.

It goes without saying that, as affecting the health of the state, the "special session" of the Legislature in the early spring of 1889 was the most important, because perfecting a law which made uniform, through a Board of Commissioners, rules and regulations controlling transportation movement of individuals and freight from place to place in the state during a prevalence of epidemic disease. It also provided methods for imparting and enforcing instruction in personal and community hygiene and sanitation throughout the state. Eighteen hundred and eighty-nine was memorable in that the state awoke from a Rip Van Winkle sleep of apathy and indifference affecting health to a realization of a greater fact, that if Florida was to become rightfully in possession of what was due her, the preservation of the health of the people must be made the big asset in development.

*(To be Continued)*

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## DR. WILLIAM LELAND HUGHLETT

In the death of Dr. William Leland Hughlett, September 17, 1925, the Florida Medical Association loses an active and enthusiastic member, the community in which he lived a beloved physician and the state an able advocate and legislator.

Dr. Hughlett was born in Lancaster, Virginia, October 16, 1861. Honor graduate of medicine from the Medical College of Virginia in June, 1884, and served as house physician at The Retreat for the Sick in Richmond, Virginia, until October, 1884, when he located in Rockledge, Florida. He practiced his profession in Rock-

ledge until 1890 when he moved to Cocoa, Florida.

He was many times president of the Brevard County Medical Society, President of the Florida Medical Association about 1900-1901. Member of other medical associations including the American Medical Association.

He availed himself of post-graduate work at Mt. Sinai Hospital, New York, the New York Polyclinic and at Johns Hopkins and has visited the Mayo Clinic on two occasions for special work.

Dr. Hughlett served Cocoa as Mayor for twenty years and represented the 13th District of Florida as Senator in the State Legislature from 1916 to 1920.

## LEST WE FORGET

Florida, a mecca for tourists, home-seekers, those interested in investments and climatic advantages, is having an unprecedented stress placed upon all of its facilities.

It would appear that one of the greatest human tragedies that is now being slowly and insidiously enacted under conditions which will lead to a dramatic and terrible climax, is the apparent abandonment of the program of inoculating humans against typhoid and para-typhoid.

It has been said by conservative medical and public health authorities that the occurrence of a fatality from typhoid in this modern time of preventive medicine, constitutes a criminal act.

Thus far in Florida for the year 1925, one hundred and seventeen reported deaths from typhoid fever appear in the reports of the Bureau of Vital Statistics of the State Board of Health.

One need only travel by automobile over a small portion of this state to obtain a convincing demonstration of the public health hazards; the people are everywhere camping along the roadside, and in crowded tent cities under conditions of no water, no sewerage, soil contamination with typhoid infected feces, fly infestation, and a re-enactment, really, of those days which twenty years ago kept doctors at home in the summer time treating typhoid and infantile diarrhoea.

The loss of a citizen in the upbuilding of a state is said by students of political economy to amount to five thousand dollars. It is, therefore, not difficult to conceive the financial loss experienced, or the more serious results of the future under a neglected public health program.

It behooves every doctor, every educator, every member of a civic club and every man who has the interest of his state and of his fellow-men at heart, to enlist the services of every instrument for the spreading of the information; newspaper, radio and similar agencies, urging everyone to protect Florida against the occurrence of these diseases.

The State Board of Health, hampered by restricted finances, although plenty of money is available, can do but little other than in an educational way. It seems that the Legislature provided for a one-half mill tax for the State Board of Health, but specified the budget of expenditures which permits the State Board of Health to spend only approximately fifty cents out of each dollar that goes into the present fund for the operation of the State Board of Health. There will thus be builded up a large sum of money to the credit of the State Board of Health which they cannot spend. It is probable that the present State Board of Health will influence the law at the special session of the legislature to be held this month, whereby the money can be made available.

### THE USE OF CHLORINE

With the opening of school and the coming of winter there will appear a large number of patients seeking relief from colds. We will be constantly prescribing for them, whether using one remedy or another.

Our correspondence will increase with personal appeals from distributors of proprietary remedies, vaccines, etc., each recommending its own products, augmented with a few testimonials. Amongst the most persevering will be firms who have invested various sums in the manufacture of chlorine gas. Some will tell you of its value and others will be frank enough to tell you patients demand it. They frequently do, but it is our duty to prescribe what in our own judgment seems best and to refuse to prescribe remedies if we are not satisfied of their value.

No one can read the reports of Sawyer and other army officers and then not be willing to try chlorine, but few would use it after reading the report of the New York Board of Health. Between these extremes are a happy medium where most of us should put ourselves. It is our opinion that the use of chlorine in certain cases has been very satisfactory. But failures have been more common.

Intelligent observations should be made, recorded, and reported, so that those with limited opportunities may profit. Chlorine may be a valuable remedy in certain types of respiratory infections, but it must stand the test of time. Until then, impartial observations will aid materially in arriving at proper conclusions.

### THE DISCUSSION OF MEDICAL HEALING CULTS

Frequently the physician is called upon to discuss with laymen the numerous healing cults that are being inflicted upon the public. Too often their discussions are made with a quite meager understanding of the particular cult. All medical men know that our own science is based upon the soundest principles. However, we cannot discuss fairly and accurately the numerous cults without an understanding of their methods and the basis for their existence.

Recently Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association*, has published a treatise entitled "The Medical Follies", published by Boni and Liveright, New York, which analyzes the foibles of Osteopath, Chiropractic, Electronic Reaction of Abrams, together with essays on the Antivivisectionists, Health Legislation, Physical Culture, Birth Control, and Rejuvenation.

The following is excerpted from the introductory chapter:

"Most primitive peoples explain disease as the seizure of the body by demonic or evil influences. Obviously the cure of disease, if the theory be accepted, rests on the conjuring of the demon from the body. Thus arose the belief in the healing powers of the priest craft and in the value of the incantation or the prayer that the priest might utter. Thus, too, came the determination of the remarkable virtues that seem to be inherent in the laying on of hands, for the priests and the medicine men and the healers of all types soon found that the incantation or suggestion, accompanied by physical contact, was far more efficacious than the simple prayer in securing results.

As Maddox has indicated in his study of "The Medicine Man", the notion of a divine call to the work of representing heaven on earth, is not peculiar to any one age, race, religion, or state of civilization. The healers of the savage tribes were convinced that their powers came to them from a divine source. It will not surprise us, therefore, to learn later that the leaders of our



modern medical cults likewise believe themselves to be divinely inspired. The medicine man of the savage tribe was frequently marked by some mental or physical peculiarity, such as a hunchback, gigantic size, a powerful voice, or some similar divergence from normality. The leaders of our modern cults are also the possessors of magnetic personalities that mark them early in their careers as not quite usual in their habits of thought. Finally, the medicine man of the past was invariably a profound student of the psychology of his people; he knew the simple nature of their mental processes; he understood the importance of the fundamental urge of sex; he realized that a strong claim is far more convincing than a weak one if neither can be proved.

From such an ancestry in the childhood of mankind came the great apostles of certain healing cults that have arisen in the United States during its brief history. Some of them have pursued a brief career and then passed into the limbo of forgotten things. The cults established by others have continued over half a century, bringing to the high priest and his disciples the plaudits of the credulous Babbitty, and something more than a good living."

It will be well worth while for the members of our Association to peruse carefully this volume. Only by an understanding of the various types of quackery may we intelligently enlighten our patients as to their fallacies, and, as physicians, this is an obligation to our patients and to the public.

Dr. Fishbein is eminently fitted to present the subject, both from the standpoint of accurate knowledge of the cults obtained through the American Medical Association and because of his ability as a writer.

#### STATE NEWS ITEMS

*This department is supervised by Dr. Ralph N. Greene, Jacksonville. Members of the State Association are requested to forward to Dr. Greene or the Editor such news items as they may think of interest to the readers of THE JOURNAL.*

Dr. John S. McEwan, President of the Florida Medical Association, recently honored the Duval County Medical Society with his presence at the regular monthly meeting of said society, upon which occasion he read a paper dealing with affairs of organized medicine. This

paper will appear in an early issue of THE JOURNAL, and should be read carefully by every one who receives THE JOURNAL. Doctor McEwan is possessed with a rare and enviable gift of expression and is capable, because of his literary talent, his administrative ability and his natural power of leadership, of writing articles which should be of wonderful benefit to the profession which he represents.

Dr. Joseph Halton has returned from a four months' trip to England and France. Doctor Halton joined Dr. John S. McEwan, Orlando, President of the Florida Medical Association, at Paris, where they made a systematic survey and study of the hospitals at the French capital. It seems a waste of good printer's ink to state that Doctor Halton lives at Sarasota. (Joe, how does this publicity seem to be?)

Dr. Benjamin F. Barnes of the Florida State Hospital Staff, Chattahoochee, is convalescent from a severe infection of his right hand and forearm, resulting from the infection of a wound incurred by the breaking of a radio tube. Dr. Barnes was in the hospital for a number of days following an operation aimed at controlling the infection, the operation having been performed by Doctor Folmar, assisted by Dr. John Beggs.

Dr. J. Knox Simpson has returned to Jacksonville from the meeting of the American College of Surgeons, Philadelphia, at which meeting he received a fellowship in the American College of Surgeons.

Dr. John E. Boyd, Jacksonville, was recently in attendance upon the meeting of the American College of Surgeons at Philadelphia. Doctor Boyd and the author of this column of news items should receive a gold button because of enduring the torments of attempting to practice medicine and at the same time run hospitals that are inadequately financed. Mail all contributions to Doctor Boyd.

Dr. R. H. McGinnis of Jacksonville was recently ill for a few days, but is now convalescent and has resumed practice.

Dr. W. L. Van Landingham, Secretary of the West Palm Beach Medical Society and Superintendent of the Good Samaritan Hospital, West Palm Beach, was a recent visitor in Jacksonville.

Dr. James H. Pittman, West Palm Beach, was recently in Jacksonville.

Dr. H. D. Van Schaick has returned from a five weeks' visit at the Mayo Clinic and at Chicago hospitals.

Dr. John S. Helms of Tampa was a recent visitor at the American College of Surgeons' meeting in Philadelphia.

The State Board of Medical Examiners, at their recent meeting in Tallahassee, examined one hundred and ninety-five applicants to practice medicine in Florida.

Among the questions asked was one requiring the definition of the term "Keel breast." A package of Camel cigarettes will be awarded to any doctor who can answer this question without first looking in numerous books. Address all answers to Dr. James H. Randolph, St. James Building, Jacksonville.

Dr. Marv Knott of West Palm Beach is attending Pediatric Clinics in St. Louis for a period of five weeks.

Dr. Thomas Buckman, formerly connected with the Harvard Medical School, has opened offices in Jacksonville. Doctor Buckman's work will be limited to pediatrics.

Dr. F. Clifton Moor, Tallahassee, bitterly resents being called "Grandpa." Doctor Moor says that the baby is a niece, bearing part of his name and that he does not propose to be relegated by this "Grandpa" stuff to the third generation of ancestors.

Dr. J. C. Davis, Quincy, is actively engaged in formulating plans for the next meeting of the Second District Medical Society to be held at the Florida State Hospital, Chattahoochee.

Dr. O. O. Enzor of Burksville, Texas, has recently moved to Crestview, where he expects to open a hospital at an early date.

The doctors of Okaloosa County are planning to organize a County Medical Society in the near future. Up to this time they have been affiliated with the Walton County Medical Society.

Dr. E. Porter Webb of Crestview suffered the loss of his wife in September. Mrs. Webb has been a chronic sufferer for many years. Besides her husband she leaves one son, one daughter and one grandson to mourn her loss.

Dr. Louis Stinson, notice of whose untimely death at Hosford has appeared in the press of Florida, will be missed by his host of friends throughout the State, particularly in Jacksonville where he practiced his profession for a number of years. There has not been time for a formal resolution from the Duval County Medical Society, but the same will doubtless appear in the next issue of THE JOURNAL.

Dr. Thomas E. Buckman, chief of the Pediatric

Service of the Boston City Hospital and instructor in pediatrics at the Harvard Medical School for the past five years, has moved to Jacksonville, and will have offices at 513 Laura street. Doctor Buckman will present a paper before the Section on Pediatrics at the Dallas meeting of the Southern Medical Association.

Dr. M. P. DeBoe of Miami has been spending some time in Chicago and New York.

At the quarterly meeting of the Second District Medical Society held in Monticello, October 14, the following program was found most interesting:

1. Spider Poisoning—Dr. H. E. Palmer, Tallahassee, Florida.

Discussion led by Drs. J. B. Brinson, Jr., Monticello, Florida, and W. F. Yarbrough, Miccosukee, Florida.

2. "Puerperal Eclampsia, A Case Report"—Dr. Geo. B. Glover, Monticello, Florida.

Discussion led by Drs. J. C. Davis, Quincy, Florida, and B. A. Wilkinson, Tallahassee, Florida.

3. Ovarian Tumors in Childhood, with report of large Ovarian Cyst with twisted Pedicle, simulating pregnancy in a child of ten years—Dr. Wm. W. Massey, Quincy, Florida.

Discussion led by Drs. F. R. Godard, Quincy, Florida, and J. Kent Johnston, Tallahassee, Florida.

4. Myocardial Dysfunction—Dr. W. C. McConnell, Chattahoochee, Florida.

Discussion led by Drs. J. C. Davis, Quincy, Florida, and F. M. Woodall, Chattahoochee, Florida.

Following the scientific session, supper was served at the Women's Club to all physicians and their ladies.

The following Florida doctors were noted among those attending the Clinical Congress in Philadelphia last month: Drs. John E. Boyd, F. A. Waas, R. B. McIver, J. Knox Simpson, E. H. Teeter, N. M. Heggie and Shaler Richardson of Jacksonville, and Dr. John Helms of Tampa.

Dr. F. C. Ingram of Orlando has been spending some days in Chicago attending Clinics.

Dr. M. A. Lishkoff, Pensacola, is spending some time in Chicago and New York. He expects to return home about the first of the month.

Doctor Hodson of Miami is sojourning in the West. Following the meeting of the American Academy of Ophthalmology and Oto-Laryng-

ology in Chicago; he journeyed to California for a vacation and on his return the latter part of this month he will attend the meeting of the Southern Medical Association in Dallas.

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#### STATE BOARD OF HEALTH COLUMN

Dr. W. A. Claxton, formerly District Health Officer in West Florida, but recently in the United States Veterans' Bureau Hospital at Oteen, North Carolina, has resumed his connection with the State Board of Health and will enter at once on his duty as District Health Officer in District No. 2, with headquarters at the Miami Laboratory.

Dr. L. M. Coulter, recently of Yonkers, New York, has been appointed District Health Officer in District No. 3, with headquarters at Tampa. Doctor Coulter served in the Medical Department of the army during the World War and has since had special study and experience in public health work. He was in his early youth a resident of St. Augustine, where his father practiced medicine.

Dr. D. S. Fraser, recently with the International Health Board at Andalusia and Montgomery, Alabama, has been appointed District Health Officer for West Florida and will go immediately to his district. His headquarters will be in the State Board of Health Laboratory at Pensacola.



## ABSTRACT DEPARTMENT

## DERMATOLOGY

*Granuloma Pyogenicum.* A clinical and histological review of twenty-nine cases. H. E. Michelson, M.D. *Archives of Dermatology and Syphilology.* Volume 12, Number 4.

The article is of more than passing interest because the condition described is often confused with sarcoma, epithelioma, angroma, and chancre. "A history of previous injury is nearly always obtainable. *Staphylococcus aureus* is usually present, but it is not known definitely whether it is the specific exciting cause." The location is in the majority of cases the exposed parts of the body, although no skin or mucous membrane is immune. The lesions are ordinarily pedunculated but may be sessile. Histologically the tumors are made up of granulation tissue covered with epithelium which is usually eroded, if not it is quite commonly thin over the vertex of the mass. Therapy consists of destruction of the lesions by carbon dioxide snow, ultra violet ray, electro-cautery or removal by the Keyes biopsy punch. Local recurrence is common unless destruction is complete. The article is well illustrated by schematic drawings and photographs.

J. L. K. S.

## OTO-LARYNGOLOGY

*Catarrh or Sinuitis.* Nathan P. Stauffer, M.D. "The Laryngoscope," September, 1925. Vol. 35, No. 9, p. 697.

Dr. Stauffer uses the word "catarrh" as borrowed from the laity expressive of a symptom that he believes has its origin from infection in the paranasal sinuses. To illustrate the wide variety of accompanying symptoms in catarrh that are attributed to sinuses infection he has selected 12 cases from his practice and their case reports show in conjunction with the chief complaint symptoms such as headaches, eye pain, deafness, shingles, acute arthritis, indigestion, hoarseness, exhaustion, nervous prostration, asthma, phobias and manias. All had sinus infection in varying degrees and all were either relieved or cured by proper medical or surgical treatment. Many of them were cases of long standing, yet under treatment the catarrh promptly cleared up and prove to him that catarrh can be cured.

In the matter of diagnosis he differentiates under the main symptom—acute rhinitis, or vasomotor rhinitis and a chronic sinuitis. The first is of short duration and begins with a watery discharge; the second has a discharge tinged with pus and is persistent and here he includes any cold that does not clear up in two weeks and the patient continues to use many handkerchiefs or is bothered with hawking. "It is easier to diagnose in men than women because ladies frequently are unaware of the post-nasal drop and will swallow it."

J. L. B.

## PEDIATRICS

*Treatment of Scarlet Fever with Antitoxin.* Francis G. Blake, M.D., and James D. Trask, M.D. *Boston Medical and Surgical Journal*, October 8, 1925.

The literature on the subject is briefly reviewed and opinions given as to indications for treatment with respect to time and dosage and results to be expected in uncomplicated scarlet fever, scarlet fever with septic complications and post-scarlatinal sepsis.

Fifty-seven cases of uncomplicated scarlet fever are reported, forty-eight cases with complications and seven of post-scarlatinal sepsis treated with Dochez's unconcentrated serum by intramuscular injection.

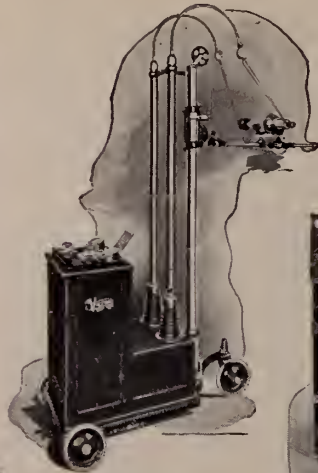
The uncomplicated cases were promptly cured in from 12 to 36 hours. Of the complicated cases all but one promptly recovered, while no benefit was observed in the seven cases of post-scarlatinal sepsis. Antitoxin is indicated in all cases except in instances of marked septic complications after termination of specific toxemia and fading of the rash. The therapeutic action of the antitoxin consists solely in its ability to overcome specific toxemia and it should be administered early in the course of the disease and before the septic phase has become a factor. Even in septic cases it should be given provided the rash is still present.

The intramuscular dosage suggested is from 3,000 to 8,000 units for children, depending on severity of case, and from 4,000 to 12,000 units in cases of adults.

J. D. L.



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—James Harvey Robinson in "The Humanizing of Knowledge"

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## ORGANIZED MEDICINE IN FLORIDA\*

J. S. McEWAN, M.D.,  
Orlando,

*President of the Florida Medical Association.*

The time has come for us, the members of the Florida Medical Association, to wake up, put our shoulder to the wheel and place ourselves where we belong, among the leading states of organized medicine. Dr. H. Marshall Taylor, of the Duval County Society, in his Presidential address in Orlando, May, 1924, called the attention of the Association to this important matter and suggested the slogan "One Thousand Members."

In his article he states that Florida has the lowest percentage of physicians members of the State Society than any other Southern State. Our statistics, at the present time, in the A. M. A. Directory, 1925, are not reliable, as it gives us the same population we had in 1923.

Florida is growing rapidly, in fact she is booming. Physicians are taking our State Board examination by the hundreds and we must make these men members of our County, State and National Societies, and make them assume their responsibilities with us in taking care of the Public Health and Medical Legislation.

In Chapter 2, Section 2, of our Medical Ethics, it says—

"In order that the dignity and honor of the Medical Profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with Medical Societies and contribute his time, energy and means, in order that these Societies may represent the ideals of the profession."

A man ordinarily benefits from any organization in the exact proportion in which he himself tries to help. In other words, he gets out what he puts in.

We must increase our membership, increase our dues (we have provided for that in our new constitution and by-laws which should be adopted at our next meeting), and then we will be in a position to demand the necessary laws or the modification of present ones to protect our State

from the numerous quacks and pathes who are over-running it.

Your State Association should have the power of recommending to the Governor the men whom he shall appoint on our examining board. I shall suggest to the Committee on Legislation and Public Policy, of which your Dr. Milam is Chairman, that this matter be taken up without delay.

The educational feature of the County Society should appeal to all of us; they measure our efficiency and the discussions broaden our outlook and our patients profit thereby. The meetings promote good fellowship, make us better acquainted with one another and so promote friendships, thereby tending to better understanding and help do away with the back-biting and petty jealousies with which we are at times afflicted.

We find the irregulars and other physicians joining together in one society, for what: to amend the Medical Practice Act so that we will have reciprocity and so that it will be easier to become licensed to practice in our State. And you all know what would happen if we had reciprocity. We would have a physician in every hotel, boarding house, etc., and the state would be full of quacks of every description. We are in a peculiar position. It seems to be difficult for the laity to understand we are protecting them as well as ourselves. They seem to think we are like a trust, forming a combine to keep other men out. We want other physicians, we welcome all other ethical and qualified physicians who intend to become permanent residents, but we do not want the snow-birds, who spend the winter here and then fly back north in the spring, collecting from their friends during the winter, and leaving the physicians who own property to pay their taxes for them and build them roads to ride upon.

I am appointing twenty-one councilors, one from each of the Judicial districts, to serve until the next annual meeting and then these men are going to try and get every ethical man into some County and our State Association, and I am asking each one of you to help this Councilor by handing in the name of any new physician who is not a member of your local Society and induce him to join. By so doing, you are doing

\*Address to Duval County Medical Society, November 3, 1925.

your part for organized medicine in helping to put the State of Florida in the lead, where we belong, instead of at the bottom. The importance of the Councilors cannot be overestimated.

These states, whose Councilors are on the job, are the best organized and the most efficient units of the medical organization in the United States. A good President and a good Secretary can do a great deal, but the best President and the best Secretary cannot accomplish nearly as much without the help of active Councilors as can a President and Secretary of even ordinary ability if the Councilors are alive and active in their work.

Our Journal has been published regularly since the new editor took charge, and all of you know it has improved in many ways, and today is a credit to our Association.

I do not see how our State Board of Examiners can keep a check on all the men practicing in Florida, with their limited time and funds. It seems to me we should employ some one to go around the state inspecting men and diplomas and reporting same.

We have men practicing medicine in Florida who have never seen the inside of a medical college, and you know all of these men. They have state licenses, some of them, granted by old Boards, and it is said we cannot stop them. There must be some way and the only way I can suggest is publicity. There are crooks among the regulars, among the Homeopaths, among the Eclectics, among the Osteopaths, and I believe the best men in all these lines desire the humbug to be prosecuted as they should be.

Nothing is more dangerous than active ignorance.

The best check to any given evil is always that provided by an educated public opinion. The quack who is unable to find a public on which to prey, goes bankrupt. Consider for a moment the despised cults, all of them, any of them. Have we ever taken a leaf from the book of the cults? We boast of our organizations; we abhor the cults, quacks, charlatan, with all their works and abominations. And yet we have much to gain from a mere glance at their methods. Their first approach with respect to their patient is psychological, applied psychology, and it is effective from the first. We may deny it, but our denials do not change facts. The psychological effect is produced sometimes without the sign of a treatment, but here is an improvement, im-

mediate, in the mental attitude of the patient which invariably produces an improvement in his physical condition. As one neurologist of wide experience expressed it: "The mere fact of anything being done for some of these unfortunates is curative from the psychological point of view." And when it comes to organization, we surely must take off our hats to the cultists. There isn't a Medical Society in the land whose avowed purposes does not include resistance to their practice, not one. And yet, when the cultist finds it necessary to obtain a license for the practice of his cult, he pays no more attention to organized medicine than if it did not exist. He organizes himself, and he organizes the influences that must be brought to bear in his behalf, whether they be social, professional or legislative. Year in and year out we bewail the presence of the cultist in our midst, and year in and year out he grows numerically stronger, until he finishes by having a recognized position in spite of all that organized medicine has done.

It is all very well for us to treat it lightly, to say with Barnum that the public likes to be humbugged, or with Commodore Vanderbilt, the public be damned, but it doesn't seem to occur to us that perhaps there is an intangible something that makes its irresistible appeal that has eluded our own sophisticated perceptions. We haven't taken the trouble to find out; they are quacks, charlatans, and that is all there is about it. But it really isn't finality; too many really intelligent people claim to have been benefited or cured, as the case may be, by these same charlatans. And organized medicine stands by, merely disgusted and disgruntled. Why not face about, investigate more fully, ascertain whether the cults have anything to offer to organized regular medicine and adopt whatever is worth while? Our antagonism has not been effective, that much we must admit; why not try some other tactics to deal with the situation? It is practically the same now as in the dim past, as it will be in the veiled future, since past methods of dealing with the situation have failed, why not devise others?

There is no denying the fact that the place of the physician in the community, whether he be organized or unorganized, is changing and is in process of being changed by forces entirely outside of his ken, and utterly beyond his control. The laws and statutes that are put into effect every year, which must govern his actions as those of his lay brother, are carried through

without considering him as in any way concerned, personally or in his profession. Some large milk organization wants to get rid of the small milk dealer, therefore, propaganda and legislation in favor of the large organization, because it can carry its activities further. The late Dr. Jacobi, of New York, spent fifty or sixty years campaigning for pure milk for the babies of New York, and it was through the private philanthropies of Mr. Strauss that most of the missionary work was effected. He, Dr. Jacobi, the Father of Pediatrics, was expelled from the staff of a hospital because he insisted that the children three months old, in the abominable heat of mid-summer in the congested district of New York, should be kept indoors in the heat of the day, without any clothes on, and with all the windows open. From one of the pulpits came the dictum: These are Christian babies and they must not be allowed to go naked! And the intellectual attainments and professional skill and social usefulness of a medical giant were ignominiously kicked out of a children's hospital a few short years ago in progressive New York City. What has this to do with organized medicine? It ought, although it cannot be said that it always does, convince the members of organized medicine that their opinion and practice should govern in purely medical and health activities, even if the fact is that their opinion doesn't govern. The blockheads and obstructionists are just as active today as ever they were, and organized medicine doesn't seem to undertake to do much about it.

Organized medicine, as we know it, isn't progressive; that we are content to go our way doing good, following the practices of our high calling in our solicitude for the sick and suffering, all the while not fully awake to the fact that our neighbors, at every turn, are depriving us of our professional practice, and that we continue to entertain ourselves, and one another, at our medical meetings with medical matters, when our activities should be applied in an organized way to directing public opinion and getting the credit for it withal. Our mission in life is being determined for us, and sooner or later we shall be compelled to be a part of the forum and the market-place, as Dr. A. Lawrence Lowell said about our entry into the League of Nations. It all must affect us, whether we like it or not, and we might as well join in and take our part in directing it.

## HEMORRHAGE IN THE NEWBORN\*

N. L. SPENGLER, M.D.,  
Tampa.

Hemorrhages of the newborn are quite frequent and occur more often than formerly believed. They are important not only because they often cause death, but because their influence may be far-reaching in after life in the production of many mental conditions which are not so well understood at present.

The usual method of grouping is into two classes, Spontaneous and Traumatic. Spontaneous hemorrhages may and do occur from almost any part of the body, but principally from the mucous membrane. They are more profuse than the other hemorrhages, have a tendency to stop after a limited time and are much improved by proper treatment. Infection and sepsis have not proven to be causative factors with any regularity, since hemorrhages occur in only a small percentage of these cases. The cause of bleeding in these cases is seldom established by definite pathological lesions at post mortem.

The traumatic group are those cases in which an injury is received prior to birth or during a difficult labor, with an oversize child with average outlet, or average child with small outlet. Violent uterine contractions, often aided by the use of pituitrin, causes a rapid delivery, not giving time for a gradual moulding of the bones of the head, is also a cause of hemorrhage.

The application of forceps, often on posterior or antero-posterior positions of the head with rapid and continuous extractions, is also an aid to the production of hemorrhage. Hemorrhage does occur, however, when none of the above mentioned traumatic conditions have occurred, showing that we must always be on the lookout for hemorrhage in the newborn.

The two main factors to consider in studying the cause of hemorrhagic diseases in the newborn is (1) a study of the composition of the blood, and (2) the tissue walls of the blood vessels. A study of the recent literature does not clearly set forth the cause of hemorrhagic diseases of the newborn, but some of these experiments will be of some help. It has been found by a study of fifty infants that the mean systolic pressure at birth is 55 mm.; the mean diastolic pressure is 40 mm. The systolic pressure in-

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg May 19-20, 1925.



creases more rapidly with the age of the patient than the diastolic pressure. The pressure varies in proportion to the length of the child and is also increased by toxic condition of the mother at the time of birth. Another prominent causative factor in the production of hemorrhage is birth pressure. In testing the resistance of the vascular system in mature and premature infants by a vacuum suction cup on the skin, the following information was obtained: Birth weight below 1000 gm., 150 mm. hg.; 1000 to 1500 gmm., 250 mm. hg.; 1500 to 2000 gm., 310 mm. hg.; 2000 to 2500 gm., 400 mm. hg.; 2500 to 3000 gni.; 4500 mm. hg., and over 3000 gm., 520 mm. hg. This would indicate that the smaller the child at birth the easier would be the production of hemorrhage; and explains the regularity with which hemorrhage of the small premature infants occurs, because the birth pressure would exceed the blood vessel resistance in the delivery of these cases. The birth pressure as just stated with a fragile vascular wall in a premature would be conducive to hemorrhage, explaining the more frequent occurrence of hemorrhage in these types. In a normal born infant with fragile vessel walls and a tendency to bleed from some deficiency of the blood structure would account for hemorrhage in the infant of average size at birth.

A study of the literature does not reveal any marked changes in the blood stream that would cause hemorrhage except that if any of the blood elements, such as prothrombin, calcium salts, thrombo-kinase, thrombin and fibrinogen are absent you get an imperfect clot to the degree of the absence of one or more of these elements and then you have continuous bleeding.

At birth the blood stream at once begins to undergo rapid changes, and much work has been done on blood of newborn infants, hoping some characteristic blood picture would lead to the adoption of some definite substitute which we could employ in these cases. Up to the present time I cannot say that this object has been attained. We know the average platelet count is around 300,000 and a platelet count of one-third this amount will show a good clot, and when the count reaches 60,000 the clot is slightly more flabby. From 60,000 down the retractility of the clot diminishes until it reaches about 40,000 when the retractility of the clot ceases. The active substance seems to be in the platelet itself and does not pass into the surrounding tissue

when they are broken down, because a platelet extract has little influence in increasing retraction.

Hemorrhage of the newborn is very frequent and may occur in any part of the body. The most serious are probably melena, intracranial, and duodenal ulcer. Melena begins usually on the first to the third day after birth, and seldom occurs after the fifth day. The bleeding is profuse and is from the digestive tract as shown by the frequent vomiting of blood and the bloody stools. The hemorrhage is severe and the mortality is from 40 to 50%.

Until recently duodenal ulcer has been overlooked. Its most frequent site is in the posterior wall of the duodenum. Few granulations are present, and little inflammation. These ulcers have often been overlooked at autopsy. Of the cases reported 70% have occurred from the sixth week to the fifth month. These cases of duodenal ulcer run about the same course as ulcers of the adult type. The symptoms are often overlooked, because they are only present in about one-third of the cases. Frequently death occurs suddenly with some digestive disturbance, or peritonitis when perforation occurs.

Localized pain is of no value, and vomiting of blood and bloody stools are suggestive of duodenal ulcer, and when once bleeding begins usually continues to a fatal termination.

In order that a clear understanding of intracranial hemorrhage may be had it is advisable that a study of the circulation of the brain be made, because these conditions differ from those found in later life. The brain has a rich blood supply and is enclosed in a soft compressible bony case whose edges are not yet united.

The arteries enter the brain at its base and are practically unaffected by compression of the skull. These vessels are distributed to the brain and the venous blood collected into the large tubular sinuses. Pressure during birth on the brain forces the blood to collect in the large inelastic tubular sinuses, thus relieving the danger to some extent of rupture of small vessels, carrying blood from the brain tissue. The blood from the medulla is emptied into the spinal veins, which are not affected by pressure during birth. This anatomical study shows that every effort is made by nature for the free egress of venous blood from the brain, so there will not be any back pressure added to the vessel walls, which

if ruptured during pressure from labor would result in fatal hemorrhage.

Recent autopsies on infants dying the first few days after birth has revealed that the cause of 50% of these deaths are due to intracranial hemorrhage.

The prophylaxis of this condition could certainly be improved by having someone to take charge of baby at birth, and do a coagulation and bleeding time on all infants and if found to be in danger of hemorrhage from these findings use some hemostatic. A small hemorrhage which would not show any symptoms at this time would be prevented by these measures. This is so important that I am sure in all well regulated hospitals where obstetrics is practiced this rule will be followed as a routine.

At birth there is almost always some degree of asphyxia, caused from cord around neck or strangulation, with a purple color or cyanosis. In contrast to this you have the non-rigid flaccid child with relaxed jaw, purple lips, and livid skin, and is often resuscitated with great difficulty.

Along with these symptoms is the child who refuses to or cannot nurse or nurses indifferently. The location of paralysis is of no value, because it cannot be elicited with any certainty in these young patients. Convulsions may occur, difficult breathing, and sudden death. In the supratentorial hemorrhage, the fontanell will be bulging and give signs of intracranial pressure, and if much pressure is made on fontanell it may produce convulsions. In infratentorial hemorrhage you do not have quite so much distension of fontanell. A lumbar puncture will help decide the location of hemorrhage.

The treatment of hemorrhage of the various types of the newborn may be classified into three groups. First, the simple hemorrhage of the mildest type all of which have a tendency to stop without treatment. An injection of human blood, horse or rabbit serum is indicated and should be used, for in many of these cases the coagulation and bleeding time may be normal and the hemorrhage will continue, and it is also true that you may have little hemorrhage with delayed coagulation and bleeding time. In the prolonged cases of bleeding and in melena human blood from mother is best to employ. First, it is always available and avoids delay. It should be used first subcutaneously and later intravenously. Blood transfusions are best given to these

patients in the frontal sinus, entering your needle in middle line of posterior angle of anterior fontanell.

A paraffin lined syringe should be used and blood forced out by air pressure or a specially designed syringe can be had for this purpose.

At this point arises the question of the necessity of typing blood of mother and infant before transfusion. These infants by some authors have been treated as universal receivers, and this precaution has been disregarded.

Recent study of the blood of both mother and child has shown that only about 50% of infants are universal receivers, and if the theory of typing is to be regarded as of value both mother and child should be grouped before transfusion.

In intracranial hemorrhage transfusion is of no value. Human blood or some hemostatic should be used. The supratentorial type of hemorrhage is benefited by lumbar puncture and sinus puncture. The surgical treatment is decompression.

Infratentorial hemorrhage is treated by use of some hemostatic and repeated lumbar puncture the result of this treatment is spectacular in its results at times. The pressure in the fontanell is relieved, followed by bright appearance of child, a desire to nurse, and improvement in respiration.

Lumbar puncture can be repeated as often as every two hours, with complete drainage of spinal fluid. If patient continues to bleed and repeated lumbar puncture is not done, the symptoms will recur and may result in the death of the patient.

#### SYNOPSIS

It has been shown by autopsy on still-born infants and infants dying soon after birth that hemorrhage is the cause of death in 50% of these cases.

The immediate determination of coagulation and bleeding time after birth and the employment of prophylactic treatment will greatly reduce the early death rate of infants. The use of mother's blood subcutaneously, intravenously and the employment of lumbar puncture will stop hemorrhages, lower the death rate, and prevent serious and permanent injury to the delicate brain tissues. Lumbar puncture should be performed oftener, because no harm can be done and often information is obtained revealing hemorrhage. The treatment is simple and effective.

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## DISCUSSION

*Dr. J. D. Love, Jacksonville:*

Perhaps many of us are not aware of the fact that the toll exacted of newborn infants through intracranial hemorrhage is in excess of that exacted of the puerperal mother through sepsis. Intracranial hemorrhage is by no means a new pathological condition, but on the other hand is one that has been recognized from generations back. It is rather singular, perhaps, but at any rate the consensus of opinion among pediatricians is that this condition occurs at the present time more frequently than ever before, and it can hardly be considered as a mere coincidence that its increased frequency is more or less contemporary with the general employment of obstetrical pituitrin. We have seen so many cases of intracranial hemorrhage which followed the use of obstetrical pituitrin that we are disposed to regard this agent as being more potent for harm than any other drug or agency which has come to the attention of the medical profession in a great many generations. I do not mean to decry its employment in the hands of conservative men, but I do claim that wherever it seems to be indicated, before its employment, grave consideration should be given as to the evil potentialities of this agent.

I feel that in the treatment of these cases more attention should be given, probably, to prophylaxis than to actual treatment.

I agree with Dr. Spengler that shortly after birth the coagulation time of infants should be taken, and certainly this is so in these cases which have been associated with a prolonged period of difficult labor, or a very speedy labor. After that the coagulation time should be taken daily. It is a simple procedure and one that can be done in a comparatively few minutes. I would warn, however, against the mistake that is frequently made in recording normal infant blood as being the blood of a hemophiliac, because we know that at the time of birth the coagulation period is about from five to nine minutes or an average of about seven minutes, and that the coagulation time rapidly becomes prolonged until about the

fifth or sixth day it is much in excess of what it was the first day, and it is only about the tenth day that it assumes its normal coagulating characteristics. This is due, of course, to the fact that the thrombin and other contributing agencies with which the child was born is more rapidly consumed than manufactured.

As to the treatment of these cases I would warn against the too free and indiscriminate employment of lumbar puncture, because of the fact that it is dangerous to a child suffering from hemorrhage. A child suffering from cerebral hemorrhage must be treated in no way different from an adult who is suffering with any form of concealed hemorrhage.

Also, too frequent handling of the child must be regarded as a very dangerous procedure. It is dangerous even to have a lumbar puncture done once or twice daily.

I would warn also against allowing active suckling on the part of the baby because this also increases the tendency to intracranial bleeding. They should be fed expressed breast milk and water.

After all, our greatest efforts should be to avoid a condition which is fraught with such grave and serious possibilities.

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*Dr. DuPuis, Lemon City:*

This paper is certainly one of interest. There is nothing more inspiring than the early life of the infant.

Dr. Spengler has thoroughly covered the subject—has more than taken care of it, but there is one point that I want to emphasize.

*Prevention* is our only safeguard. We meet these conditions and we dispose of them the best we can. But the thoughtful physician tries to prevent trouble.

It has been my fortune, or misfortune, to attend a great many infant births in the obstetrical room and have never seen a hemorrhage subsequent to or before the use of pituitrin, and have used it in at least 90% of my cases. The fact of the child being brought into the world is a natural phenomenon, but many women do not allow themselves to be in a natural condition, or allow themselves to live under normal conditions, during the days of gestation. The arrangements in the obstetrical room, also in hospitals, in many cases, are far distant from calm and quiet which should surround a patient at this time. Also, a great many doctors have some plan or thought in



mind and allow themselves to be restless and nervous at the time they are going to attend the incoming birth of a child. I think that it is quite often the attitude or repose of the doctor that permits these conditions which we lay on to drugs.

I believe, with a calm patient in a quiet room, and a few simple things, the best results are obtained, instead of so much hurried routine and paraphernalia, which unduly arouses the patient and puts her in a condition where she cannot cooperate with the natural forces of Nature's way of birth. We should appreciate as a normal event the incoming of a child into the world.

In regard to pituitrin, I would like to say just a little bit. There are times for everything. If we give pituitrin too soon, or when not indicated at all, we will get everything out of time. If a man reverses his automobile while going at a rapid rate of speed forward, he will cause serious trouble with the entire mechanism of his machine. You can do similar things in the obstetrical room, whether pituitrin is blamed for it or not. When given in small doses in cases where it is indicated, I believe that it stands first of all drugs in the obstetrical list.

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*Dr. H. Mason Smith, Tampa:*

There is very little that I can say about hemorrhage in the newborn, except that recently I have come in contact with a few cases of cerebral hemorrhage.

The most pronounced and outstanding recovery which has been obtained in the cases I have seen, was that of a case which I recently saw in consultation with Dr. Watt of Ocala.

Five days after a difficult instrumental delivery this baby developed convulsions. When I saw it on the sixth day it was still having convulsions and had many cranial nerve palsies. The fontanels were bulged out and the baby was almost in a state of cyanosis. On lumbar puncture nothing but pure blood was obtained. The fontanels receded and the complexion of the child cleared up. Dr. Watt later gave hemostatic serum. For two or three days that child, as I remember, remained normal, but finally again the fontanels bulged, and this procedure was repeated. At present all of the cranial nerve palsies have cleared up and the child is a normal three-month old child.

In the treatment of this child we used as a guide for lumbar puncture the distention or

bulging of the fontanels. I am of the opinion that these spinal taps should be made when the fontanels tend to bulge—in other words, I believe that by preventing continued pressure on the young brain cells you prevent any destruction of these cells, and probably prevent such mental condition as feeble-mindedness from occurring later.

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#### CONCLUSION

*Dr. Spengler, Tampa:*

There is nothing special to add to what has been said, but I appreciate very much the free discussion given to the subject, and I hope that it will result in lasting good and benefit. I appreciate your discussions very much.

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#### PERSONAL OBSERVATIONS IN GAS BACILLUS INFECTIONS\*

H. D. VAN SCHAICK, M.D.,  
Jacksonville.

The object of this paper is to call attention to the necessity for prompt diagnosis and vigorous treatment in infections by organisms of the gas gangrene group.

Since the first description by Welch in this country, there has been a great deal written on this subject. The World War, with ideal conditions for the occurrence of these infections, produced a large literature but very few useful additions to our knowledge of this dread disease.

There are several organisms that cause gas gangrene, the main one being the bacillus *aerogenes capsulatus*. There are also several types of the disease described, simple, mixed, and fulminating. This knowledge, however, is unimportant as compared to knowing whether or not the patient has this terrible infection at the particular time in question, or whether his life is liable to be menaced by it later.

The occurrence of the organisms in clothes, on the skin, in the dirt, and elsewhere, should put one on his guard whenever an open wound of any kind is presented for treatment. The greater and more extensive the comminution of tissue the greater the vigilance. Wounds produced about mills, streets, and railroads are particularly prone to be complicated by gas infections. All of our cases originated from one of these. Fifty per cent had positive Wassermanns.

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\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg May 19-20, 1925.

The diagnosis should be made as soon as possible. The patient appears unusually prostrated but his mentality is good. The temperature and pulse will be noticed rising or the temperature will already be high and the pulse quick and not too good volume. The dressing will be stained, blood-tinged, and seems too small for the part. There is a thin discharge with or without bubbles. Real early it is only at the instant of removal of the dressing that a few bubbles will be seen coming out with the first flow of pent-up secretions. There is a curious odor associated with gas gangrene that, once the two are associated, puts one on his guard immediately. The sutures, if present, are tight. The wound, if open, looks sallow or blanched and visible muscle lacks its lifelike color.

Palpation with gloved hand, at the first touch may give crepitation, but early, owing to the small number of bubbles in the subcutaneous tissues, they become sufficiently separated on pressure that the crackling sensation disappears.

Smears obtained from a swab thrust deeply into the wound, shows the organism with proper staining. This may be confirmed in a few hours by shaking up the swabs with salt solution, and injecting this into the heart of a guinea pig. Five minutes later the animal is killed and body incubated for six hours. At autopsy the organism is recovered from the spleen, liver, kidney and other viscera of the animal.

X-Ray is valuable, but we have used it in only our first case reported. We have hesitated to use this method further in a general hospital, as extra care is taken when the warning is sounded and removal to isolation ward immediately the diagnosis confirmed.

Treatment—There is no way to determine definitely just which wounds will or will not develop the infection, therefore the responsibility of recognizing this complication early rests entirely with the doctor. This is only done by frequent and careful dressings at eight-hour intervals for the first seventy-two hours. When secondary operation is done and foreign material such as shot dirt, clothing, etc., are found, the same care must be exercised as following the original injury.

Immediately after the diagnosis is made the wound should be opened widely, preferably with a general anesthetic, ethylene being excellent for the purpose, as it is almost impossible to work satisfactorily otherwise. Many free longitudinal

incisions thru the fascia should be made and muscle planes separated widely. Dakin tubes should be inserted and the wounds loosely packed with gauze. We give at least 3000 cc. fluid each 24 hours, by mouth, rectum, or subcutaneously. One ounce of glucose in a glass of water, alternating with one-half dram baking soda in water, is given every four hours. More fluids and nourishment are given according to the patient. 2 cc. of one-half per cent chlorozene solution are instilled into each Dakin tube every 30 minutes, day and night.

Dressings are done frequently and any spots or pockets of crepitation are immediately incised. This treatment will take care of the majority of cases, but as the necessity arises, amputation by the simplest and quickest method should be done. Flaps should be packed with gauze and not sutured.

When blood stream infection is encountered, the patient rapidly passes away. Large doses of mercurochrome and blood transfusions might avail and will be the method used in the future.

In our series of six proven cases one died, a mortality of sixteen and two-third per cent. He had a blood stream infection. One lost an arm. He was seen late, forty-eight hours after injury, and hand, wrist and forearm were practically gangrenous at that time. One lost about fifty per cent efficiency in arm and elbow. One lost twenty per cent function. The other two recovered with no more impairment than would have been expected from the original injury.

Case No. 1, J. T. M. White, male, age 52. July 1, 1922, sawmill accident.

Compound comminuted fracture both bones left forearm. Under ether the wound was cleaned, fractures reduced and muscles sutured. Dakin tubes inserted. Twelve hours later patient's temperature and pulse rose, the wound showed a few bubbles upon removal of dressing but no crepitation. Swabs were positive. With gas oxygen anesthesia wound opened widely. Multiple longitudinal incisions down thru the fascia with insertion of Dakin tubes. The usual treatment was instituted. A positive Wassermann and a chronic nephritis were also found.

Outcome—Recovery. Fifty per cent function.

Case No. 2, 26328. D. C. White, male, age 33. December 15, 1923. Sawmill accident.

Long, deep lacerated wound right forearm. Primary suture with gauze drains elsewhere. He was first seen forty-eight hours later. Ad-

vanced gas infection present. Bubbling and crepitation to above elbow. Hand and wrist cold and pulsation in neither artery at wrist. Smear and inoculation were positive. Under ether multiple free incisions thru fascia with wide separation of muscles. Dakin tubes inserted. Forty-eight hours later an amputation was done. Blood culture negative.

Outcome—Recovery. Loss of arm.

Case No. 3. 26293. L. A. White, male, age 20. December 24, 1923. Automobile accident.

Compound fracture left tibia middle third. Operation. Wound cleaned. Dakin tubes inserted and skin closed with silk worm gut. Eighteen hours later, at second dressing, temperature and pulse were rising, and a thin serous discharge with characteristic odor from wound. No bubbles, no crepitation. Smears positive. Wound opened and Dakin tubes inserted. A positive Wassermann was later discovered.

Outcome—Recovery with 100 per cent function.

Case No. 4. 29122. N. D. White, male, age 18. November 1, 1924. Sawmill accident.

Traumatic amputation left leg, lower third, by torsion. Operation, under gas oxygen hemorrhage checked, stump trimmed and flaps left partly open. Eighteen hours later, at four a.m., nurse reported a hemorrhage with a curious odor. Examination showed a profuse bloody tinged serous discharge with a few bubbles. Smears and guinea pig inoculation were positive. The wound was freely opened and hot potassium permanganate packs applied. His convalescence was uneventful. It is of interest to note in this case, that in spite of a healthy granulating stump, and every means used, the gas bacillus was not found until Dec. 6, 1924, or thirty-six days after injury.

Outcome—Recovery. Good stump.

Case No. 5. 26514. J. M. White, male, age 18. Automobile accident.

Compound fracture lower third left femur with hemorrhage. Operation, light ether administered, hemorrhage checked and Dakin tubes inserted. Twenty-four hours later a thin discharge with very few bubbles noticed. Smears positive. The usual treatment instituted. Three hours later he was in poor condition. Blood cul-

ture taken, which later proved positive for gas bacillus. Twelve hours later patient died.

Outcome—Death. Blood stream infection.

Case No. 6. 26120. White, male, age 38. November 24, 1923. Sawmill accident.

Lacerated wound inner aspect right forearm with severance of nearly all muscles. Operation, ether, wound trimmed, muscles sutured and primary union attempted. Twenty-three hours later a discharge with few bubbles seen, slight crepitation. The usual free incisions with insertions of Dakin tubes was done. Smears and guinea pig inoculation were positive. The Wassermann was positive.

Outcome — Recovery. Function eighty per cent.

#### CONCLUSIONS

1. Be suspicious of all wounds from suspected sources.

2. Eight-hour dressings for the first 72 hours that the earliest manifestations of gas infection may be detected. These are: rising temperature and pulse, discharge with an odor, bubbles and crepitation.

3. Confirm diagnosis by smear and guinea pig inoculation.

4. With a general anesthetic open wound widely, free longitudinal incisions thru fascia, insertion of Dakin tubes and careful post-operative care.

5. Amputation by simplest method when needed without suturing flaps.

#### DISCUSSION

*Dr. W. W. Kirk, Jacksonville:*

I just want to emphasize that in the gas bacillus infection the organism is a large square-ended gram-positive bacillus, which is found early in large numbers and is quite distinct in its appearance. With these findings in a large, traumatized area, have animal inoculation made and you can depend upon it. I think that a diagnosis can be returned from the swab in the vast majority of cases, which will later be confirmed by animal inoculation, but that by swab diagnosis from eight to twenty-four hours will be saved for the patient.

*Dr. DuPuis, Lemon City:*

I wish to report one case in appreciation of Dr. VanSchaick's paper on gas bacillus infection, as I feel that he has written a very excellent paper and I appreciate it very much.



Those of us who have had cases which developed gas gangrene, know that it puts us to our wits' end to save the patient, there is no question to that.

This case was a negro man of 35 years of age. The left fibula suffered a compound fracture. The right leg was shot just above the ankle and practically severed the bony structures by a dynamite explosion, leaving a space probably two inches in size.

This man was put to bed with Dakin's solution applied to the wound, and kept there during the crucial period, to see what would develop afterward. The second day he developed gas gangrene in the foot—seemed to have been partially circumscribed. We left that foot on for two days. It seemed to be below the wound, confining itself to the foot. The second day it was just a little above the margin of the wound itself. We amputated it up high, just below the knee, so as to give him the use of a good stump. He had considerable shock from the operation. The following day he had a little temperature, and within twelve hours after that you could smell him on the porch as soon as you reached the ward. The condition was recognized even by the odor.

The sutures were removed and the stump left open. It struck me that we would have a dead darky in a very short time unless something could be done, and done quickly. The thought then struck me that we had had very good results with Dakin's solution, and that if we would get below the subcutaneous tissue with catheter perforated or drainage tube, and let Dakin's solution in under and above the infection, that we would possibly get some results—in other words, heading off the infection. This was continued for twenty-four hours continuous drip, with the stump sitting down in the solution of one-half per cent Dakin's solution, wrapped in a cotton pad, the solution covering the wound.

I want to say, that when we started this irrigation there was marked infection for about four inches above the stump wound, and the tissue was dead two and one-half to three inches above. When these tubes were put in, I might say it was Dakin's or something else, but it was as spontaneous as I am going to sit down, the gangrenous process ceased, and the patient recovered with a subsequent amputation and useful stump.

## THE NEED AND ADVANTAGE OF A MENTAL HYGIENE MOVEMENT\*

G. H. BENTON, M.D.,  
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Mental hygiene is a branch of the science of physical hygiene, and a general understanding of the same is as advantageous as the process of cleaning the teeth, washing the hands and face. The need of other branches of physical hygiene has been well understood and admitted. The need of mental hygiene can easily be understood when one expresses the theme in the following terms, "The spreading of a common sense gospel of right-thinking, in order to approach a better way of right-living". Physical hygiene is described as the promotion and preservation of health. Mental hygiene, therefore, would be the preservation and promotion of mental health and, as life is continuous adjustment of internal arrangements to external relations, a necessary knowledge of mental hygiene would not only preserve mental health but, by its adoption, would procure better physical and social contentment.

Mental hygiene seeks to promote and preserve both mental and physical health in the direction of right and efficient living. Hence, the advantage of a mental hygiene movement, which tends to place within the grasp of the greatest number of people a knowledge of the possibilities and opportunities of personal and collective benefit, with the aim to secure good mental development, extension of mental capacities and the ability to adequately use them. The promotion of good always means prevention of the harmful. Mental hygiene also takes into consideration the subnormal and abnormal states, the retarded and advanced intellectual states with a desire to establish a happy medium in reactions, reducing friction on the one hand and increasing accomplishment on the other; all in the direction of better adjustment and greater efficiency.

There will be no attempt to cover the subject of mental hygiene in this paper. Merely the briefest outline of its aims and advantages. Volumes would be required to express the factors and possibilities of mental hygiene. The definition: "An integral factor in the science of biology" is entirely inadequate for a rational com-

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prehension and fails to express the necessary impression of what is intended to convey an explanation of the range and possibilities of a mental hygiene movement. The object of mental hygiene is intended first, to establish in the minds of the profession, and through them to the laity, a rational conception of the biological factors which may influence, benefit or control by better mental mechanisms, the actions and reactions of the individual, the basis of which, of course, is an understanding and proper interpretation and application of the ordinary biological entities: namely, mental mechanisms. This demands observation, investigation, research, thereby establishing facts, leading to the correct interpretation of the factors discovered from which rational deductions can be made; thus establishing theories and principles as the basis for the adaption of rules of action for the guidance of individuals in the various and varied fields of human activity and endeavor. Mental hygiene deals not only with the primary reaction induced entirely through the autonomic states, better indicated perhaps under the term, "Emotional responses", but the more technical and advanced products of mental activity involving intellectual states, including comprehension and judgment.

An adequate conception of the needs of the individual during the constructive periods of character building remains in the hands of comparatively a few, while the understanding of how to meet these needs and secure the best results obtainable is within the understanding and training of still a lesser number of individuals; and for these reasons, while much attention is generally given to the more or less correct breeding and training of domestic animals, horse, cow, hogs, chicken and sheep in particular, the human species is left to chance and incidental environmental influences, with too little thought, and no conception, of the possibilities in the direction of harmful or beneficial influences to which the individual may succumb.

How few lives comparatively are planned, regulated or executed on the basis of any rational formula including a reasonable understanding of the intrinsic factors which require elaboration on one hand, or on the other hand extinction or modification during formulative periods of character building.

How many individuals realize the extreme ease with which habits, good or bad, beneficial or injurious, are formed and even less, perhaps,

of how much in bondage one is held by one's habits?

How few also recognize the automaticity of habits and that habits, good or bad, are the result of frequent repetition, and thus that habits are both automatic and many are also established in response to autonomic states.

This admitted: how simple it may become to first comprehend the needs of a given individual, then formulate a method of procedure, satisfying these needs, thus establishing desirable habits of reactions opposed to careless methods, or worse: no method, resulting in harmful, haphazard, or indifferent habit reactions.

The individual personal entity needs must here be distinguished from the similar class needs and the greatest comprehension and understanding of the personal reaction to autonomic stimuli whether normal, hypo or hyper reactivity is induced. Then such means of education and re-education through adequate explanation, comparison and understanding be established as is necessary to correct the harmful reaction; relieving tension states resulting in the unfavorable reactions or impressions arising therefrom; thus securing more useful psychic and physical adjustments.

The need and the advantage of a mental hygiene movement is readily conceived from a consideration of the factors comprising the basis of human endeavor which constitute our very existence.

Beginning with our personal biological entity, existence, a knowledge of our libido, which means our energies and other inherent forces and desires which make natural demands for gratification; environment and how it impresses us, and how we react to it, and by understanding, how we modify it or adjust ourselves to it or fail to do so. What we perceive of either the tangible or the abstract. Ideas, affective states, manner of behavior of selves or other persons. Our personal relation either to or among the foregoing. The continual and ever-changing individual and social relations; of events, important and insignificant, presented in an infinite variety of similar and dissimilar situations, all demanding an equal variety of adjustments involving danger, risk and responsibility. Joy, sorrow, encouragement, depression, etc.

From the mental hygiene standpoint and view, the most importance must be attached to the personal possession of handicaps or incapacities

or the freedom from such, the normal adequate vs. the normal inadequate, normal here as elsewhere signifying the average; the average individual here handicapped by the feeling of inferiority, continually making unfavorable comparisons between himself and others, the discouragements arising from unstable judgments and decisions arising from past painful experiences, expressed in him in the line of inferior adjustments of excessive difficulty in decision of conducts, of what is best or right, the necessity of choosing between situations involving desire, self-gratification, personal advantage or relief from difficulties or other unpleasantness on the one hand as opposed to duty, self-denial, self-control, facing of unpleasant situations or the inevitable which are constant and ever-changing elements in our environment.

Every individual possesses certain capabilities of execution in relation to certain things, those inherent capacities as thinking, sensing, feeling or craving result in ingrained tendencies to either direct the use or application of these capacities or to be used by them, they are our internal self-directing capacities and the arising activities result in our behavior.

These forces, while they exist extra-physiologically, they cannot take place without involving physiological activities. They are really psychobiological entities and are embodied in our conception of the term: mind, psychia, hence psychobiological. Every activity, occurrence, concept or whatever transpires in ourselves or our environment, makes a record on the mind, an engraving which is preserved as an individual psychic record of all our activities or capacities for activities. It is thus a dynamic entity, which we describe for want of a better term, as a state or states of consciousness.

The normal segregation of these "dynamic capacities" fall in two groups, embracing divisions and subdivisions. First and foremost, the driving forces of our lives. This is the most fundamental, constant and primitive: existing in all living specimens, which we express as the libido, an urge to be, to exist, to construct and repair one's self, to make necessary or beneficial adjustment, to be independent and biologically efficient.

Thus, these with other psychic activities, are coordinated into the semi-intellectual states, which we recognize as instincts, a capacity for using our inherited structures in an ancestral

manner, giving rise to the acquisitive state (desire to get: first food, then self-preservation, later other wants, including wealth and knowledge, etc., self-protection and to acquire the ability of self-protection, to escape danger or annoyance, to reproduce, to seek a mate, beget and rear young, to establish a home, etc., to satisfy desires and wishes to secure relief from discomfort as of hunger, bowel and bladder tensions, pain, disagreeable emotions, difficult situations, to avoid criticism, adverse public opinions, feelings of inferiority).

The receptive capacity and those activities by which we acquire knowledge of our individual self and understand our environment. The former receptive capacity by which we perceive or sense things, apprehend external objects, modes of energy, comprehend the presence and use of our anatomical mechanisms, hands, feet, limbs, organs of special senses, etc., relations between these and the elements of external environment, as automobiles, railway stations, etc., etc., ad infinitum.

The internal elaborating mechanisms, our thinking capacities, by which, through the libido, instincts and desires, we are able to appropriate all kinds of material supplied through our receptive and other activities from our external environment, resulting in intellectual and ideational states, which include recalling past impressions, sensory, ideational, affective, behavioristic and conative, through psychic association and comparison and apprehension we are able to symbolize, thus forming concepts, abstract ideas, generalizations, comparing the resulting impressions, sensations, etc., weighing relative values, forming judgments, reasoning, drawing inferences, guessing, theorizing, imagining, forming associations, expecting, anticipating, dreaming, whether asleep or awake, fantasies, making decisions, choices, forming plans, purposes, resolutions, forming ambitions, ideals, in fact, psychic activities of all kinds, whether voluntary, controlled or directed, or uncontrolled, whether "conscious", "co-conscious", "sub-conscious", "fore-conscious", or "unconscious", as you will, combined or associated with the next group of activities. These give us sentiment, psychic attitude, points of view, complexes, prejudices, superstitions, the affective or emotional capacities and activities or reactivities. The real unconscious involves activities by which we are affected, resulting in our feelings and beliefs.



constituting individual conduct and behavior. The more intense reactions of this same sort are expressed as joy, sorrow, elation, grief, fear and anger, embarrassment, disgust, shame, and result in our moods. Primitive instinctive reactions expressed as affective attitudes as antagonism, cooperation, pessimisms, optimisms, etc. And from all, in association, we arrive at our personal executive capacities and accuties through which we put to use our capacities, and perform the various acts representing our individual adjustment to environment, be it good, bad or indifferent.

Mental hygiene deals with the application of these facts and principles learned from the science of actual concrete problems of living. It is, therefore, applicable under all conditions of human existence and can be applied to the home and the family primarily, inculcating an understanding of each member of the family, securing a better atmosphere, proper attitudes, encouraging the parents to set a satisfactory example of reaction and conduct, and help them to better understand the needs and possibilities of the child. In the school: in an endeavor to secure both good physical health conditions, proper understandings of the relation between the teachers and the pupils, the personal needs and abilities on the part of the pupil and how to supply these needs, how to vary them, and modify them, expand them or diminish as best to suit the pupil's capabilities. In our industrial institutions: with the hope of establishing harmonious relations between the representatives of the financial head and the laborer, to establish better reactions between the employees, to see that the work and worker are properly fitted to each other, to detect and correct misfits. In the courts, both juvenile and adult: creating a better understanding by court officers of the mental, personal, social and other environmental factors in delinquency and crime, with some knowledge of the individual needs and ability to forecast, in some measure, the proper effect of punitive measures. In the penal and reformatory institutions: particularly where, by virtue of the class of people inhabiting these institutions, a knowledge of their particular individual needs and their attitudes toward them; ability in the direction of classification, employment and segregation. In our hospitals, in our churches, amongst our peoples and nations: so that you see mental hygiene's principal need can be ap-

plied to our institutions, to our persons, to our parents, to our children, teachers, employers and managers, employees, physicians, clergymen, judges and the public in general.

In a mental hygiene movement, then, with such an extensive field and with such eminent possibilities, requires great effort and energy, and careful planning and a certain degree of specific refinement to insure best results and to prevent the unfortunate miscarriage of events, as has been demonstrated, unfortunately, so often in welfare work generally. This is due, in a great measure, to the dominant emotional response in the welfare worker who, without knowledge of the real needs of the situation and no competent idea of the work to be accomplished, but through a great desire to help. It very often not only fails to help but makes the situation much worse. By virtue of their undue sympathetic attitude often, unfortunately, they furnish suggestions which are not in keeping with the needs of the patient, and from which arise fixed mental attitudes which are very hard to remove. The untrained social worker, or one who lacks competent training, reacts unwittingly to the influence of the spirit of the times, exactly on the same basis as the individual, and it becomes a matter of the blind leading the blind.

The best results are obtained by definitely organized procedure, which has been more or less perfected and refined by virtue of the experience gained in its application. The National Committee of Mental Hygiene has, for a number of years, conducted their affairs along such lines by which they establish in cities, where possible, first, the psychiatric clinic, in which workers are trained in the theory and application of mental hygiene measures. Around this psychiatric clinic are grouped the subsidiary factors, through the different social workers, the home, the school, the court, the church, and, in a large measure, the general community; and, by virtue of their considerable experience and the methods which have been tried out and proven satisfactory, it is quite rational to follow, so far as possible, in these footprints. The guidance of the National Committee of Mental Hygiene, where they assume charge and control of a clinic, is beyond the means of the smaller municipalities. Based on these experiences and the needs of a community, the National Committee on Mental Hygiene requires a five-year contract, a minimum fund

of which is \$40,000 per year for maintaining a clinic. This is outside of the range of most communities in the State of Florida. However, in an individual way, much can be done to improve the present situation without this great expense. Many municipalities have Community Chests and other eleemosynary institutions which can assist in more individual plans of operation, so that much work can be accomplished and a great deal of good, with whatever means is already in each community.

When the general public interest is aroused and the advantage of a mental hygiene movement recognized, I think its advantages will be appreciated and without great splurge and great pretense, much can be done with even the present limited resources; preparing the field for greater activities on a much larger scale when the opportunity accrues.

### DISCUSSION

*Dr. Ralph N. Green, Jacksonville:*

Dr. Benton has presented a paper dealing with a subject which is, of course, interesting to all, but more particularly to the Psychiatrist. I had in mind, during the reading of Dr. Benton's paper, the work of Watson, entitled, "Psychology from the Viewpoint of the Behaviorist". This work perfectly expounds the theory that every act of human conduct is dependent upon a definite stimulation, and with a retrospective instrument every human conduct can be traced back to the stimulation and the stimulation classed, and then such corrective measures as will replace human conduct may, in some respects at least, be properly applied, which will attach some explanation to the problem of mental hygiene.

When we consider that the insane asylums of the United States have more insane people today than there were at the beginning of the War, and that the annual cost of maintaining these institutions, as shown by the cancelled vouchers of the State Treasurer, is sufficient to build, actually complete in detail and pay for them, six Panama Canals; and when we consider further the number of feeble-minded, due to unrestricted marriage laws, it should at least give us a rational position when we raise the question of why put the cart before the horse.

After broad experience, the Psychiatrist has unfortunately come to the conclusion that once insane, with some exceptions, remain always insane, and if insane, the only thing that humanity can do, in a general way, is to give them institu-

tional treatment, in order that they may be cured if we are in time, as time is the controlling factor.

Mental hygiene is in its infancy. I do think that we, who are present here today, will live to see the practical application of mental hygiene in our different communities as we should like to see it applied. In a city of 100,000 people a proper mental hygiene program would entail the expenditure of \$30,000.00. But I am convinced that humanity at large is not so much interested in saving human lives as they are in saving dollars. If we could show the community that the amount spent was not over \$30,000.00, and that the money, properly applied to the employment of properly trained personnel, would replace court procedures and murder trials that cost many times more dollars than the expense of operating a mental hygiene clinic, we might get somewhere with it.

We have all seen the results of unrestricted marriages on human upbuilding, and yet a number of doctors have presented bills requiring the Wassermann test on all persons contemplating marriage, and they were promptly turned down by the Legislature. An insane person may be discharged from the asylum, walk into the nearest County Court House, pay a small fee, and obtain a marriage license.

On looking back on the sad experience of not a few times, I assure you, having stood in the shadow of the gallows and seen some poor wretched human life hurled into eternity and the ends of justice met—I have felt in each instance that somewhere humanity has erred and that I have witnessed a tragedy, which is parallel to allowing a human life to be cast into a yearning chasm, unrestricted, and into a horrible death.

These things are sentimental, but some day may result in a practical application of a constructive program.

*Dr. H. Mason Smith, Tampa:*

I think that Dr. Green's remark, "once insane, always insane", with a few exceptions, is somewhat extravagant. Probably all of us have seen many patients and many people who were below par, and would not work in accord with the conditions by which they were surrounded, but when given a change of position and surrounded by the proper influences, have become normal in behavior and reaction, become adjusted and made good citizens.

Just at this time I think the need of a mental hygiene movement in this State is very striking. We have a great exodus of people coming to this State from other countries, many of these people are inferior mentally, and in leaving their homes, breaking the established routine, coming into new environment and into new conditions, and living by different methods, fail to make adjustments. At this time a hygiene movement could make corrections of these cases and bring about a lot of beneficial results.

One of the greatest needs of a hygiene movement is to create sentiment which will cause the State to take more seriously its responsibility in caring for this class of public charges.

As long as our institutions, which have charge of the feeble-minded and other inferior people, are controlled by men who are elected to office, and who use these institutions as instruments in obtaining office, we will not reach a very high standard of caring for this type of patients.

*Dr. E. J. Melville, St. Petersburg:*

I believe that this question should be taken up in the public schools. We have this situation at the present time in the Florida graded schools. Unfortunately, they take children into the schools without grading them at all. Of course, the idiots, imbecils and feeble-minded do not reach the school, but, nevertheless, a great many morons, both low and high grade, are taken into the schools. I think that when the school opens, as in the Fall of the year, that all children should be graded.

They should be graded: low grade morons, high grade morons, normals, intellectuals, super-intellectuals, and geniuses. And, instead of putting them all through the same hopper, when a child reaches, say the fifth or sixth grade, as a great many of these high grade morons can, then that child should be taken out of school and put to a good manual trade; because if that child is left in the school, in a very short time we will have a delinquent on our hands.

I think this movement should be started by physicians in every city, through the School Board. Go before the teachers and explain to them how to give children the psychological mental test. I think that a child at three can be tested, and an ordinary psychiatrist can tell exactly how much education that child will be able to take. Three may be a little young, but they can, and it is being done in some of the cities, and

I think we should start that movement in every town and city in Florida, and start it now. And I believe that it is up to the doctor to grade these children, and we will not then have so much delinquency, and will not have so many of our boys up before Court, as we have here in our State boys who are now going to school and not understanding the work that they are trying to take up.

After they have gone as far as they can, they should then be taken out of school and colleges also, and put to some trade. Many of them will make very good tradesmen, but would be unable to go beyond the fifth or sixth grade.

If we do this, and do it now, we will keep these low grade morons from becoming potential criminals.

*Dr. DuPuis, Lemon City:*

The last speaker has caused me to be here. I did not expect to speak on this paper. I never expect, while I live, to see all of the people graded, especially children. I do expect to live to see the time when the doctors will wake up and take part in the mental hygiene movement and education in general.

The doctor who spoke of the morons, said to give these boys a trade to follow. An excellent suggestion. How many people in our American citizenship today are equipped or qualified to go out and take the position they themselves are seeking? Sad to say, a very, very few.

We have forgotten one of the greatest factors that has saved humanity in its progress in our present-day civilization, and that is the one word "work". Work has done more to conserve, systematize and utilize the thoughts of the human mind than any other word that has ever been coined from the English language. Take the graded schools. Do not try to teach a feeble-minded child a lot of composition and history, but give him something to improve his mind and teach him to work and utilize space and time, instead of becoming a parasite. Teach him a useful trade and in that way give him the most progressive education we have or can record for the utilization of individuals into useful beings—whether provision for grading and teaching is ever effective or not.

*Dr. G. H. Benton, concluding:*

I think that I have very little to add, owing to the limited time that we have this morning.



I feel very grateful to Dr. Greene particularly for bringing out those points that were so very important, in such an impressive way, and also to the other gentlemen who discussed the paper.

Dr. Smith's idea of adjustment brings us up to the important things. Now, what we really should be interested in at this time, in the mental hygiene movement, is the conditions that exist today and how they may be brought into application or modification, how to use the material that we have to an advantage, perhaps pre-determining what we don't want or that which we cannot use, what sort of efficient work could be accomplished, if the person who harnessed the time had no idea of the work to be accomplished, or how to put the harness on the horse. What work would he get done?

Now, we have certain conditions manifested in all our people, beginning, probably, in infancy, in our schools, our churches and our courts, and in every form of human endeavor these advantageous things are going to waste and the unfortunate elements are predominating.

It is a knowledge, distributed to the general people through the medical profession, how to recognize and how to make these adjustments, that makes the mental hygiene movement of value. I feel that in the State of Florida, perhaps more than any other State in the Union, we need this movement, and we need this movement now.

### SOME OBSERVATIONS ON DISEASES OF THE THYROID GLAND\*

EDWARD JELKS, M.D.,  
Jacksonville.

In the past, the profession in Florida has not been confronted frequently with the problem of handling patients with the disturbances of the thyroid gland, but since our State is attracting people from all parts of the United States, we are finding an increasing number of sufferers from thyroid disease. It has been my observation that very few of these disturbances arise in those born in Florida or those who have been here many years. I believe, as time goes on, it will be necessary for us to keep ourselves familiar with thyroid states if we are to solve wisely the medical problem that will arise with the great growth of Florida. So I thought it would be profitable for us to consider today some phases

of the problem of thyroid disease. I am not prepared to present original ideas, but desire simply to review some of the present-day knowledge and illustrate with a few cases something of our experience.

We have accustomed ourselves to regard not so much the local irregularities of the gland, as what are their influence upon the general condition of the patient. As in the case of fracture of the skull, where the break in the bone is of less importance than the injury to the central nervous system; so in goitre, the size and appearance of the gland are much less important than the damage that has been done, and is being done, to the cardio-vascular, the nervous system and to other vital tissues.

For practical working purposes we have found to be adequate the following simple classification:

1. Adolescent enlargement of the thyroid.
2. Malignancy of the thyroid.
3. Adenoma without hyperthyroidism.
- Adenoma with hyperthyroidism.
4. Exophthalmic goitre.

The adolescent enlargements respond so readily to treatment that to control them is usually not difficult. The treatment of the malignant tumors give notably poor results. It is the adenomatous type, with and without hyperthyroidism, and exophthalmic goitre that I wish us to consider.

What is the problem of adenoma and cyst without toxic symptoms? Should they be causing an annoying sensation of pressure, as indicated by difficulty in swallowing and breathing, surgical treatment is the best method of relief. Some authorities, The Mayo Clinic for instance, advocate the removal of all adenomas in people, after the age of twenty-five or thirty years. The reason is that such a high percentage give toxic symptoms later on. We see this happened quite frequently. From our experience, symptoms begin to develop around the age of fifty, long after the patient has ceased to give heed to the thyroid enlargement.

In January of this year, Mrs. S. W. consulted us for a swelling in the neck, difficulty in swallowing, sensation of pressure on the trachea and nervousness. She was then fifty-five years old. Since early girlhood she had had a swelling in the neck, which had varied in size several times. She has lived a very trying life, has been a seamstress, and for the past few years, besides this, had nursed an aged Mother. In spite of

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this activity, she had no trouble with the neck until about a year ago, when she noticed that, although the thyroid had not increased much in size, she had begun to get nervous and suffer from symptoms of pressure. Her own words were, "I have become a physical wreck." Her weight has dropped from 130 to as low as 85, but at that time was 100.

It was very evident, at examination, that with a pulse rate of 100, beginning widening of the eye slits, loss of weight, nervousness and metabolism readings of plus 24, and an enlarged nodular thyroid, we were dealing with a case of adenoma of the thyroid with thyro-toxic symptoms. A sub-total thyroidectomy was done, with gratifying results.

Before the age of twenty-five or thirty years, it generally is thought best not to operate for non-toxic adenoma, because the gland may have some important function in the growth of the individual. Besides, adenomas removed in early life are very apt to recur.

A more important problem than the handling of these non-toxic tumors of the thyroid is what should be done when hyperthyroidism is present, with or without existence of tumor. If size and the local condition of the gland are not the determinate factors in treatment, what then ought to be our guides. How are we to distinguish the mild from the grave cases? The cardio-vascular is one of the first systems to sustain damage. The classical sign of tachycardia is a good indication of the degree of the toxicity and, to some extent, the degree of the injury which the heart has already received. In only the severe cases do we encounter actual decompensation with dilatation. It is in the adenomatous goitre that the cardio-vascular system is most likely to be damaged. The blood pressure in these we have found to be rather above than below normal. In the exophthalmic types it averages about normal.

Another group of signs and symptoms are those referable to the sympathetic nervous system; such as sweating, flushing of the skin about the neck and face, functional changes in the extrinsic muscles of the eye, and the gastro-intestinal irregularities of diarrhea, constipation and visceral pains. By far the symptoms most disturbing to the patient are the various types and degrees of subjective nervousness. These states of nervousness tax heavily the physician's powers of understanding and interpretation.

Nervousness is so universally a condition of man. It is our problem to determine in the presence, or for that matter in the absence, of an enlarged gland, whether we are dealing with a thyro-toxic state. The history and clinical picture alone often settle this question. We have, moreover, a simple test which we believe indicates with practical certainty the degree of thyroid activity, that is, the basal metabolism test. In our experience, the findings of this test correspond strikingly with the clinical picture. Those patients with struma, tachycardia, nervousness, autonomic disturbances and increased basal metabolism reading before treatment, have shown an improvement in symptoms in proportion to a degree of change in the basal metabolism estimations. The more ill the patient the higher have been the metabolism readings; while the more normal the patient, clinically, the lower have been the readings. Of equal value is the test in those cases of enlarged gland and hypothyroidism. It has shown us not infrequently that what we thought to be a patient suffering from enlarged gland and excessive thyroid secretion, was in reality a patient suffering from deficiency of the thyroid activity.

Once hyperthyroidism is discovered, what plan of treatment are we to adopt? In the first place, adequate rest should be insisted on. The adolescent types are well controlled by the administration of iodides. The syrup of the iodide of iron or iodinated salt has proven very efficacious. The adenomas with toxic symptoms, I think, are usually considered best treated by surgical removal. X-Ray or medical therapy do not rid the patient of a circumscribed tumor of the gland. It is in the treatment of the exophthalmic type that there is the greatest difference of opinion. Up to quite recent years surgical treatment was so hazardous that various other measures were advocated in this place. X-Ray therapy has given many satisfactory results.

In a town near Gainesville there is a patient whom some of you have seen, who came under our care four years ago. She was so toxic and the heart damaged to such an extent, that we felt surgery to be contra-indicated. X-Ray treatments were given. The patient immediately showed marked improvement in every way and on August 31st, 1925, her pulse was 72 at rest, metabolism rate normal and the thyroid gland practically atrophied. In the beginning the metabolism rate was twenty-four.

Medical treatment can claim a goodly percentage of apparent cures; but I think the records will prove that the surgical removal of the diseased gland is the most logical, effective and practical method of relief, provided this can be done with a minimal risk to the patient. Even before the preoperative use of iodine in the form of Lugol's Solution was adopted, the operative mortality, in many hands, had been lessened markedly by the performing of multiple stage operations. At the present time, with enforced rest, administration of Lugol's Solution, careful study of the patient's progress, clinically, and with the invaluable aid of basal metabolism estimation, the patient can be gotten into such shape that at a properly selected time a sub-total removal of the gland can be done in one stage. The patient then has been given the best chance to get well.

Let me say just three things in the spirit of warning about the administration of Lugol's Solution:

1. Its benefits in exophthalmic goitre are only temporary.

2. Do not give Lugol's Solution in cases of adenoma. They are very susceptible to iodism; Lugol's Solution may do more harm than good.

3. Be careful in its administration in colloid and adolescent goitre. Here iodism arises frequently with symptoms simulating hyperthyroidism, the very condition that one wishes to relieve.

Permit me to say in conclusion:

1. That the profession in Florida should be awake to the increase in the number of patients with disturbance of the thyroid gland.

2. That the non-toxic tumors of the thyroid present the problem of local symptoms and the possibility of hyperthyroidism developing in the future.

3. That in hyperthyroidism we are dealing with a disease which affects the vital organs.

4. That the most effective treatment in hyperthyroidism is the removal of the abnormal thyroid tissue.

5. That Lugol's Solution gives temporary improvement in exophthalmic goitre.

On May 30, 1925, Mrs. E. S. D., age 32, born in Iowa, consulted us at the direction of Dr. G. C. Tillman. Her complaint was goitre. She was familiar with this condition since her mother and sister had had similar trouble. Seven years ago, when her oldest child was one year old, she noticed that her left eye was becoming more

prominent than normal. Glasses improved her vision but had no effect upon the appearance of the eye. Immediately after this she noticed the other eye slit likewise was becoming wider. This prominence of the eye has continued to increase slowly and steadily until the present time.

Enlargement of the thyroid gland was also noticed about this time. Since then she has had two children, age six and four. During these pregnancies she noticed no special disturbance of the gland or eyes. About three years ago, however, there appeared tremor of the fingers to such a marked degree that it was difficult for her to carry a cup of coffee without spilling it. Very disturbing symptoms of nervousness developed, with lessened ability to control the motions. She had very pronounced feelings of fear. There was no cardio-vascular irregularity until about two years ago, when she had periods of tachycardia and palpitation. She has had remissions and recurrence of all the above-named symptoms but not to the degree with which they all appeared three months ago. The whole clinical picture became very acute. Since that time she has been under the care of Dr. Tillman, who put her on a regime of medical treatment, including Lugol's Solution, which resulted in general improvement and the slowing of the pulse from 130 to 112.

When she consulted us the summary of our findings are as follows:

"The patient looked moderately sick. There is a diffuse swelling of the thyroid gland with a nodule one inch in diameter in the left lobe. There is only slight dilation of the veins in the neck. The eyes exhibit a moderate degree of exophthalmus. The eye slits widen on sudden focusing and the upper lid lags behind the eye ball in its movements. There is a markedly fine tremor of the fingers. Pulse rate 120, blood pressure 140 and 80. The heart is normal except for only fair muscle tone. The basal metabolism reading is plus 23. Evidently we are dealing with a case of moderate degree of hyperthyroidism."

With rest in bed and Lugol's Solution, pulse soon returned to normal. After one week of hospitalization we did a sub-total thyroidectomy. The temperature chart demonstrates the improvement in the pulse. When the patient left she was greatly improved and had a metabolism reading of plus 6. A follow-up examination Oct. 3, 1925, reads as follows:

"Patient says she has shown great improve-



ment in every way. She is not so nervous, has gained weight, present weight of 104 is the most she has ever weighed in her life. She feels better in every way than before the operation. She is not so nervous. She notices that her eyes are not so prominent as formerly. Tremor of the fingers is not much different. Emotions are much better controlled. Pulse rate is 90, systolic blood pressure, 136, diastolic blood pressure, 90."

This case illustrates certain points of the handling of patients with a thyro-toxic state:

1. With clinical and laboratory findings it is

not difficult to determine the patient is suffering from an over-activity of the thyroid which is affecting the cardio-vascular and nervous systems.

2. In exophthalmic goitre rest and Lugol's Solution result in temporary improvement, as indicated by the lessening of general annoying symptoms, a slowing of the pulse rate and a lowering of the basal metabolism reading.

3. Thyroidectomy promises to make these improvements lasting.

## Looking Backward Over Fifty Years of Health Work in Florida

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*Former State Health Officer of Florida,*

1889 - 1917

*Serial No. 6.*

Next to the Legislative session of 1889, the session of 1915 looms on the horizon of health progress as probably one at which more health measures of any important nature were enacted than any that have been passed since. The Hon. (Dr.) J. N. Fogarty of the Senate and Hon. Forrest Lake of the House is due the credit for the passage of those important measures. It was at this session that authority was given the State Board of Health to operate a "Health Train" as a moving school of instruction in hygiene and sanitation in the rural sections. And, too, authority was also given to the railroad companies of the state, at their pleasure, to give transportation over rail lines free of any charge for the service. The several railroad companies operating in the state cheerfully cooperated in a scheme of service to the people in the rural districts, wherever their lines ran, and were as enthusiastic in this cooperation as were the health officials themselves. The cars were equipped with models and text cards by which information was given by lectures demonstrating the different phases of sanitation in homes and community life. The cars were fitted at the Pullman shops at Chicago, and were sold to the State Board of Health at such a nominal sum that the purchase should almost be considered as a gift from the great Pullman Company through the recommen-

dation of its general manager, Mr. Richard Dean, who becoming interested in the educational feature which such a visual demonstration would give the rural public, greatly assisted in the project by sending a skilled mechanic from Chicago to Jacksonville to make plans for the alteration of the interior of the wooden cars, which had been bought, to conform with the views and wishes of the state health officials. When the alterations were completed and the cars delivered the "Florida State Board of Health Train" was, with its full equipment of furnishings, one of the most if not *the* most completely designed rail moving exhibitions of its kind for sanitary educational training. To this help in sanitary education at this time, the State Board of Health was greatly indebted to Mr. Richard Dean, the then manager of the Pullman Sleeping Car System.

Not only in this instance did Mr. Dean come to the assistance of the state health authorities of Florida in health affairs, but through correspondence of previous years, he had given an attentive ear to suggestions in minor matters which, nevertheless, tended to improve healthful comfort to the patrons of the Pullman system when travelling in a semi-tropical climate. The State Health Officer of Florida had on several occasions invited the attention of Mr. Dean to

the heavy texture of the Pullman berth curtains, which kept out air needed in hot summer nights, suggesting using a lighter material to be of cotton and silk, weighted at the bottom to prevent the curtains from blowing open by the shaking of the cars when in motion. Likewise it had been suggested that the Pullman conductors be allowed to wear coats made of some light serge unlined, to replace during the summer months the heavy blue cloth then used. These suggestions were received courteously and as far as possible adopted. But the most notable change for improvement in sanitary arrangement in Pullman cars, which was recommended to Mr. Dean, was in the dressing rooms. Almost constant travelling about the state during the first years of the board's existence in 1889 had directed the attention of the State Health Officer to the disgusting practice of using the face wash-basin to clean the teeth. But how to reform the practice was a difficult problem to solve. After much thought it was suggested to Mr. Dean that this system of morning mouth cleansing could be corrected by a swinging bowl under the wash-basin fixture, connected with the water system of the basin, which when pulled out, would release a water valve, giving a stream of water into the dental bowl. Quite an interesting and instructive correspondence followed, in which the mechanical hindrances of the proposition were discussed and finally ended by the mechanical department of the Pullman System constructing a bowl on a stand for the purpose, near to the wash basin fixture. A few of the Pullman cars were equipped as an experiment and seemingly meeting with approval from the traveling public, the design was adopted and now Pullman sleeping cars have dental lavatories as permanent fixtures in all of the dressing rooms. It was not known at that time that a separate fixture for teeth-brushing had been proposed, although the repugnant practice had doubtless been frequently observed and discussed. Therefore, the proposal to correct such an unsanitary procedure should be credited to the State Board of Health of Florida, and to Mr. Richard Dean, general manager of the Pullman Company, should likewise be given thanks by an appreciative public for his support in supplying a needed comfort. This sanitary invention, therefore, should be known as "The Dean Dental Sanitary Device."

Even a partial health history of the state for the past thirty years should not omit mention of

the bacteriological laboratories which have given such valuable information to the medical profession of the state as well as of untold importance to the citizenry. As a free service offered to the people in conserving health and saving life, the benefit which these aids have given cannot be estimated in dollars and cents, not in a satisfaction acquired through investigation made of disease organisms. For ten years after the creation of the State Board of Health, its executive labored by pleading and argument which could not be disputed, to establish a bacteriological laboratory as one of the activities of the State Board of Health. It was in 1901 that with the influence of the new president of the board appointed that year, the Hon. W. S. Jennings, then Governor, the board considered the proposition laid before it by the State Health Officer and granted permission to establish, equip and operate a bacteriological laboratory at the headquarters of the board at Jacksonville. Losing no time, Dr. Edwardo Andrade, a talented academician and a man of scientific ability, was selected as bacteriologist of the State Board of Health. The immeasurable benefit obtained by the medical profession and given free to the people of the state, in quickly distinguishing disease organisms by microscopic examination was appreciated to a degree as to call for other similar bacteriological diagnostic points to be established elsewhere in the state. Accordingly, it was not long before laboratories of this nature were built and operated at Tampa and Pensacola, with branch adjuncts of the same character at Miami and Tallahassee. Thus has the state marked its progress in supervising the health of its citizens and made history for which it can justly claim due praise.

Closely connected with the management and control of yellow fever during the past thirty years are first the safeguards adopted by the State Board of Health to prevent yellow fever gaining a foothold in the state, and a wide spread from point or points. Secondly, the sanitary methods employed to protect children and adults as well from the anæmic effects of hookworm. The State Board of Health, conscious of its duty to the younger generation, sought to benefit the children living in the rural communities of the state by commencing an intensive campaign against the ravages of hookworm. An official visit to the western seacoast of the state very vividly made it apparent to the State Health Officer, who was accompanied on this trip by Dr. Hiram Byrd, then assistant to the board's execu-

tive, that no longer should be delayed in this respect, an effort to improve the health of the children of Florida, and for the matter of that of many adults. Accordingly, on return to the office in Jacksonville, a campaign was planned and Dr. C. T. Young, now President of the State Board of Health, and Dr. E. W. Diggett were sent forth with these instructions only, to obtain results by careful study of conditions and wise administration of remedies. They were equipped with microscope and drugs, and were permitted to select the territory in which to commence operations. The sections selected were thoroughly gone over, and it is believed that when they reported that their work had been finished in each, the improvement in health conditions of the children was signally observed. From an anæmic appearance, bloated abdominal figure, and listless mentality, these children of the country districts and likewise adult who could be persuaded to accept assistance, within a few weeks showed such marked improvement in physical vigor and brain activity at school, as to bring forth favorable comments from neighbors and strangers. During the period of these campaigns Drs. Young and Diggett preached rural sanitation in all of its elementary teachings. It was then stressed the importance of sanitary privies in rural districts, if hookworm would be prevented from infecting the feet of the children through fecal soil pollution, as they usually go barefooted in the country. Unfortunately, this important part of instruction was not generally heeded, as was shown by the fact that several years afterward in going over a section previously treated, a reinfection of the children was found, due entirely to neglect by parents to observe the advice given at the first visit in regard to building sanitary privies and avoiding pollution of the soil by fecal matter.

In another portion of this recital reference has been made to the immune card system for travelers from yellow fever infected ports, or places considered to be endemic foci of yellow fever. As explanatory of this system it may be told that persons whose life history showed an attack of yellow fever at some previous time, or having lived in an endemic focus of yellow fever—that is to say, in a place where yellow fever annually occurred—for over ten years, were given cards of immunity to future attacks of yellow fever, which in the subsequent epidemics in Miami and Pensacola were accepted for travelling purpose from those who were so fortunate to possess

them. While it is not disputed that individuals may have second attacks of yellow fever, yet a study of the disease has shown that such are extremely rare. For instance, in a severe epidemic of yellow fever in Gibraltar, Spain, in the early part of the last century, it was found after an intensive study of conditions attending that epidemic, that out of twenty-seven thousand cases, nine thousand were selected as probably having had yellow fever twice; but continuing the investigation still closer, the decision arrived at was only three second attacks were proven, indisputably. Having decided to place in operation the immunity card system for travel between Key West and Havana, the next move was to find a competent person to act as representative of the Monroe County Board of Health in Havana, to examine applicants for travel between Key West and Havana during the summer months, who would be skilled in the task expected of him. Fortunately there was attached to the American consulate at Havana, as civilian medical officer, just such an individual, who for thirty years had resided in Havana, was an expert diagnostician in yellow fever, besides thoroughly acquainted with the unsanitary conditions of all portions of the city of Havana at that time, and the greatly infected foci of the disease above all other portions of the city. Such a man was Dr. D. M. Burgess, and to him the Monroe County Board of Health appealed and asked assistance in this work. Having the confidence and respect of both the American colony as well as that of the Cubans, Dr. Burgess was preeminently qualified above all others to undertake the responsible task that it was desired to work out; a task in the execution of which great discriminating care had to be exercised. Dr. Burgess continued to act as the official representative of the Monroe County Board of Health and the State Board of Health at Havana, until the advent of the Spanish-American War, when he with other United States consulate officials were relieved from duty on the island. After the Spanish-American War, the quarantine system of Cuba was directed by the Marine Hospital Service—now the Public Health Service of the United States. It is a great pleasure for the writer to pay tribute to the memory of Dr. Burgess, long since deceased, but perhaps remembered very kindly by those now living of the older generation, who paid frequent visits to Havana during his connection with the United States consulate in that city, for the painstaking and



conscientious manner in which he discharged the service asked of him. The writer also feels under a personal debt of gratitude to Dr. Burgess for courtesies and kindnesses shown him when visiting Havana in closely watching the operation of the new system of immunity certificates. It was at this time the yellow fever immune cards which carried a certificate from the State Board of Health of Florida of future immunity to yellow fever came into prominence. The certificate besides containing a statement that the bearer, whose autograph signature was on the margin of the card, had experienced an attack of yellow fever, place and date, had a detailed physical description of the person presenting the same. In high regard and esteemed confidence reposed in the State Board of Health of Florida, it may be mentioned that these immune cards were accepted by other states and by the Health authorities in Cuba.

A retrospection of the management of contagious disease, dangerously communicable in Florida fifty years ago, is interesting reading, as compared with the more enlightened and scientific methods now practiced. Citizens of Florida have profited during this lapse of time, through the labors of the State Board of Health in laboratory investigations, earnestly and patiently persevered in. The work of the Board in this respect is still going on, each year multiplying the activities engaged in to the betterment of the health of the people of Florida, in the prolongation of life, and maintenance of health. With health comes ability to work; greater labors, both physical and mental, augment and promote development of the soil and likewise industries of various kinds; immigration is invited, the once waste places of the state are built up and wealth in both money and desirable citizenship has come so rapidly that it is amazing to contemplate its growth.

Is it too much to claim that an alert guardianship of the health of the state, contributing to the comfort and happiness of the people, inspired by confidence, such as the State Board of Health has exercised for nearly forty years, should not be given all credit for the place Florida now holds for marvelous prosperity in the sisterhood of states?

An incident of marked importance to the smooth running of health matters in the state occurred during the session of the Legislature of 1897. It will be remembered that the Constitution of 1885 provided in Article 19, which

deals with a State Board of Health, and its associate organization, for County Boards of Health, which the Legislature may also form. Prior to this date it had been found that oftentimes purposes and instructions from both organizations did not work out satisfactorily or to the benefit of the state as a whole or to the individual county or city therein. Particularly was this true in respect to maritime quarantine management or domestic restriction of travel during prevalence of dangerously communicative diseases. Therefore, an Act introduced into the Legislature of that year sought to abolish County Boards of Health which had been established and vest all authority of management in sanitary matters in the State Board of Health. The contention on the passage of the Act was vigorously fought by the late Col. W. D. Chipley, then Senator of Escambia County, against the measure, and the late Hon. C. A. Carson, then Senator from Osceola, championed the proposition. It passed the Senate and immediately was certified to the House, where without discussion it passed in one, two, three time, movement by the active work of the leaders in the House, the late Hon. W. Hunt Harris, and the late Hon. John N. C. Stockton. Thus the quarantine of the state and all sanitary matters pertaining to what was considered would be an efficient administration were placed under the direct control and management of the State Board of Health, and has so remained for 36 years.

*(To be Continued)*

#### PROGRESSIVE MUSCULAR ATROPHY.\*

*Progressive Spinal Amyotrophy; Duchenne-Aran's Disease.*

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Clinicians for many centuries have described progressive muscular wasting. Pictures and images in stone and wood of the muscular atrophies and dystrophies dating from the fifteenth, sixteenth and seventeenth centuries are in existence. Van Sweiten, Abercrombie and others gave general descriptions. This group was first broken into by Duchenne, in 1849, by a loose description of a special type, which a year later Aran supplemented. Cruveilhier in 1853, and Luys in 1860 sharpened the picture somewhat by their demonstration of the exclusive implications

\*Read before November Staff Meeting of the Duval County Hospital.

of the anterior horns. Charcot isolated the amyotrophic lateral sclerosis with the group. Others recognize the bulbar forms. Finally, Duchenne also called attention to the sensory anomalies in certain of his 1853 studies on the atrophies. The syringomyelias were confused for a long time with these atrophies but were finally definitely separated in 1882. Thus it took thirty years for the sorting out of the medley of muscular atrophies.

This is a disease characterized by a slow progressive atrophy of the muscles of the extremities, beginning in the uppers and trunk with consequent paralysis not accompanied by any notable sensory disturbance and due to a progressive atrophy of the lower motor neuron in the spinal cord.

*Age and Occurrence.*—Persons in the middle period of life from 25 to 45 years of age as a rule are affected. The extremes are found to range from 14 to 70 years of age. Two cases seen in this hospital were 40 years and 70 years, respectively—the younger a man, while the older a woman, both seen in the last six months. It is seen more frequently in males than females, about five to one.

Its occurrence is rather rare, being seen for the most part among workmen who do heavy work, athletes or professional contortionists. The season of the year, race, etc., apparently play a minor part in its occurrence.

*Etiology.*—The most outstanding causes up to the present time of this disease have been found to be infectious diseases especially typhoid, acute poliomyelitis, toxemias, exposure to cold and wet, overexertion, metallic poisoning (especially lead), great mental strain; syphilis may or may not cause it. Heredity is claimed by some authorities to be an important etiological factor, by others it is not considered. No known organism has been found or isolated. In the World War shell concussions probably causing minute hematomyelias, possibly vacuum caisson changes, have resulted in this disease.

*Symptoms.*—The patient suffers at first from slight rheumatoid pains in the shoulder or arm associated with some feeling of numbness and weakness. Muscular wasting then begins to appear in the intrinsic muscles of one hand. The adductor pollicis longus is very early affected, as are the thenar and interossei muscles. The atrophy spreads from muscle to muscle and does not follow the course of the nerve supply, although

the ulnar nerve is most seriously involved. The ball of the thumb becomes flattened and the patient cannot adduct or flex it well. One of the early signs is seen when the radial interossei are reached, the forefinger cannot be adducted. The disease gradually extends upward attacking the flexors more than the extensors of the wrist, then the upper arm and shoulder affecting adduction and flexion of the forearms especially. In the meantime the hand has been flattened, the wrist flexed, finger extension lost and a characteristic "griffin claw" appearance results. In from three to nine months the other wrist begins to be affected. In some cases the atrophy begins in the shoulders and arms attacking the deltoid, biceps and triceps, then extending down the forearm to the hands, thus constituting the upper arm type, but is seldom seen.

The disease usually progresses passing from the shoulder girdle to the deep muscles of the back, then downward involving the thigh muscles, glutei, crural extensors and adductors being oftenest chosen, the leg muscles usually escaping. In its descent the disease progresses to the trunk involving the intercostals. It slowly ascends the neck also and finally leads to a paralysis of the diaphragm, or a bulbar palsy may set in.

Along with the wasting there occurs a corresponding weakness and paralysis, but the paralysis always following as a result of the atrophy. In some cases the muscles are flaccid and toneless, the deep reflexes, knee jerks, arm jerks disappear early, while in some cases for the most part the irritability and tonicity of the muscles are increased, the knee jerks exaggerated, resembling very much amyotrophic lateral sclerosis. In typical cases of this disease we have no anaesthesia, cutaneous or deep, and when such symptoms appear we must suspect other diseases of peripheral involvement, syringomyelia or spinal cord tumor. The patients do suffer with rheumatic-like pains and from paræsthesia. The affected parts often show excessive sweating and congestion and evidence of vaso-motor disturbance. This may involve the face on one or both sides; one pupil may be larger than the other, the iris reflex is preserved and the optic nerve is never involved. The sexual power is weakened, but the sphincters are not attacked. The urine shows variations in the urea content, there may also be an increase in lime salts. The electrical irritability of the muscles gradually lessens to both galvanic and faradic currents, but no marked quali-

tative changes occur at first. Eventually we may get partial degeneration reactions, but they occur late in the disease unless it runs a rapid course.

*Course and Duration.*—The disease usually progresses steadily until it has reached an advanced stage when it may stop. Remissions are sometimes seen early and some improvement noted, but it ordinarily progresses again, lasting anywhere from two to thirty years or more—the average duration not over ten or twelve years. Death usually occurs from pulmonary disease due to the weakness of the respiratory muscles. Sometimes extension to the medulla takes place and involvement of the muscles of swallowing and the larynx cause death.

*Pathology.*—The primary lesion is a degenerative atrophy of the neurons of the central parts and anterior horns of the gray matter of the spinal cord, the atrophy gradually extending and involving the anterior horn. It also extends vertically, first down then up. Consecutive to this there is atrophy of the anterior roots, peripheral nerves and muscles. The disease beginning in the deeper parts of the anterior cornu involving the central and medial group of cells. These cells are more concerned in nutrition and in the finer muscular movements of the extremities, hence the atrophy preceding the paralysis or at least keeping pace with it. The lower cervical and upper dorsal segments or levels are usually affected, but others if the disease is extensive. The affected part is nearly free from nerve cells and those present are atrophied and their processes short or absent. Hardening and changes in pigment take place. The neuroglia and connective tissue cells are increased in number. The muscles show various degrees of degeneration, are pale and streaked with yellow due to fatty degeneration with deposits of fat. The interstitial connective tissue is increased and in some places entirely replaces the muscle. We also find the capillaries and small vessels distended.

*Diagnosis.*—There are several conditions oftentimes confused with this disease. (1) The progressive muscular dystrophies, (2) chronic poliomyelitis anterior, (3) syringomyelia, (4) neuritis and (5) neuritic family atrophy.

(1) In the *muscular dystrophies* there is nearly

always a history of heredity, the disease beginning usually in childhood or adolescence, the lower limbs oftener, is bilateral at the same time, is slower in progress. There are no fibrillary contractions and the degeneration occurs only very late in the disease and there is always a preceding pseudo-hypertrophy of the muscles involved.

(2) Chronic spinal atrophy or chronic (subacute) anterior poliomyelitis is usually due to syphilis. The onset is sudden and having reached its height remains stationary or improves slightly—it does not progress. The paralysis occurs first, then follows the wasting, also affecting groups of muscles physiologically related more so than does the progressive atrophy. Lumbar puncture gives as a rule a positive Wassermann, resembling tabes.

(3) Syringomyelia is practically always accompanied with peculiar sensory and trophic disturbances.

(4) Neuritis caused by metallic poisoning, especially lead, is detected by the history, pain, etc., but no progressive atrophy is seen in this disease.

(5) Hereditary or neuritic type of progressive muscular atrophy is characterized by first attacking the legs and forearms, sensory disturbance, hereditary family and typical degenerative reactions.

*Treatment.*—In the care and treatment of these cases we find it to be mainly supportive and symptomatic. A well-balanced diet of plain wholesome food, rest and quiet, along with fresh air. Local faradization and galvanization of the spine and affected parts are indicated. Massages offer very little, but very carefully applied active and passive exercises are useful. Occupational therapy has its place of usefulness. It keeps the mind of the patient occupied when doing other things, makes him forget his troubles by allowing him to feel that there are things that he or she are able to do. General tonics, arsenic phosphorus, iron, cod-liver oil or quinine are beneficial. If the patients are luetic they should have anti-syphilitic treatment to the toxic limit.

No known remedy at present is in existence, but we always feel that these patients can be benefited some.



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## THE DUTIES OF OUR COUNCILORS

In this issue of THE JOURNAL is the list of Councilors I have appointed for the ensuing year. It is necessary that all members help these men to organize their respective districts, enlist and interest all eligible members of the profession in their county in the work of the county society, and to reawaken the spirit of organized effort for the attainment of the mastery and honors of our profession.

On account of the important powers and duties imposed on the Council as a body, and still more on its individual members, for several years to come at least, the office of Councilor will be the

most responsible within the gift of the State Association. Indeed, the inauguration and success of the entire work is so dependent on what he does that no one should accept the office who will not freely give the time and labor necessary to the efficient discharge of the duties. It is necessary that every one who would qualify himself for the office should make a special study of the constitution and by-laws which his State Association has adopted, and of those which it has recommended for adoption by county societies. He should make himself familiar with the history of medicine, and especially with that of his own state and country. He should also inform himself as to the medical and health laws of the state. When possible, a joint meeting of the Council and State Board of Health should be held early in the work, in order that there may be that harmony of views and concert of action between those working for common ends essential to the results.

Possessed of the accurate knowledge and

breadth of views which will qualify him for a discussion of the necessity, practicability and objects of the organization which the profession has undertaken, and being supplied with a card index register, or other reliable list, containing the names of the physicians of each county of his district, the Councilor is ready for active work. Selecting the county, a personal letter should be written to each physician notifying him of the place and hour agreed on for a meeting to consider the advisability of such an organization of the profession of his county as will improve all of its interests, scientific, social and material. The letter should be explicit, cordial in tone and should conclude by urging him to attend and to notify and to bring his professional neighbors and friends with him. A copy of the county constitution and by-laws should always be inclosed. Unless it is shown that all of the physicians at the county seat are on unusually friendly terms the meetings should always be called at the court house, a hotel, or other place, and some conveniently located physician should be requested to arrange for the room and see that it is in order.

On his arrival the Councilor will do well to call on each physician at the county-seat, interest him in the meeting and have him call up his friends out in the country, remind them of the meeting and urge them to come in. He is likely to meet with much discouragement and to hear many doleful complaints in this part of his work, but it may be encouraging for him to know that the best and most permanent results have often been secured in counties where conflicting interests and personal dissensions at first appeared so long established and irreconcilable that all were reluctant to attend. The importance of a full attendance at the first meeting, especially of those at the county-seat, or those between whom dissensions or coolness exist can hardly be over-estimated. Such of these as fail to hear the address, to have an opportunity to take part in the discussion which follows, and to come into fellowship then, will usually prove much more difficult to deal with afterwards.

The various committees of the State Association are functioning nicely and we are in hopes that when we meet in Gainesville in the spring, that we will have doubled our present membership, and will have placed ourselves in a position where our influence will be felt in County and State health matters, and among legislators.

JOHN S. McEWAN.

## A PLEA FOR INCREASED HOSPITAL FACILITIES

The rapid growth and development of Florida is the marvel of the age. The legislative and local administrative governments have been busy trying to keep pace with public improvements, building highways and schools to accommodate the increased population. We believe that our state has much to be proud of, in that our communities have undertaken enormous and expensive developments, at the direction of the taxpayers.

We medical men who, perhaps more clearly than any one else, realize the complicated health problems which necessarily accompany this rapid influx of people and quick development of new communities, feel the need of better facilities for caring for the sick and injured.

We regret that the expansion of hospitals in this state has not equaled the increase in population. The remarkable freedom from epidemics which our state has had in the last few years is the only factor which has saved us from disgrace of unpreparedness. The medical societies should begin now to agitate the development of hospitals, adequate, at least, to care for the present population. Chambers of Commerce, Civic Clubs and other organizations, in a position to put this appeal before the public, should be interested.

We owe this duty to the state and it is high time that we undertake this work. Probably every hospital in the state should be doubled in capacity. New hospitals should be organized in communities large enough to support them.

These new institutions will not only serve the people in need of the service, but will also stimulate the physician who has had no hospital facilities to do better work.

Funds for financing hospital expansion should, of course, come through taxation. This requires an intense campaign of education for this attainment. The immediate emergencies will have to be taken care of by raising funds locally, or else having cities which already enjoy the privilege of taxation for hospital purposes utilize this privilege to the utmost.

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## THE NEWLY APPOINTED COUNCILORS

Appearing in this issue of THE JOURNAL is the list of new districts of the Florida Medical Association, based on the present Judicial Districts, and the newly appointed Councilors. The address of our President which also appears in

this issue should be carefully perused and serve as a stimulus to the new Councilors and the members in carrying on an active campaign for an increased membership. Before another year has past the one thousand member campaign should be a realization. Hundreds of medical men are migrating to Florida, many of whom are eligible and desirable as members of the Florida Medical Association. Our Councilors should play a most active role in bringing them into the ranks of organized medicine of the State. The responsibilities of organized medicine in this rapidly growing commonwealth are manifold and can not be undertaken unless the growth of the Association keeps pace with the development of the State.

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### A SUGGESTION

State Boards of Medical Examiners have a serious responsibility.

It is far better to adopt standards so elevated as to cause applicants for license to conclusively demonstrate their fitness than to adopt lower standards which will cause those who are qualified to secure a license easily under conditions which will allow the doubtful case to become licensed, even though he may be an incompetent.

After all is said and done, writing answers to questions before a State Board of Medical Examiners is not conclusive evidence of one's ability, but is about the best that can be done.

Occasionally questions are propounded, probably based on a desire to ask questions which will demonstrate more conclusively than ordinarily one's knowledge of medicine, but which, in reality, are unfair questions and at times reflect seriously on the medical examining board and the profession of the state.

The Florida State Board of Medical Examiners has a serious duty, and one calling for individual and collective sacrifice of time and effort in order to properly enforce the medical practice act.

Like all prominent bodies the board is at times subjected to criticisms.

As a suggestion to the Board of Medical Examiners of Florida the Editor of THE FLORIDA MEDICAL JOURNAL is of the opinion that if all board members would formulate their questions, and then as a body censor and modify the questions that are to be propounded before actually submitting any questions to the applicants, there would be less unfavorable reaction in the in-

stances wherein indefinite or so-called "catch" questions creep in.

At the last meeting of the State Board of Medical Examiners certain questions were propounded which caused state-wide comment among physicians and criticisms on the part of applicants before the board, which did not reflect credit where credit, we all know, is properly due.

A consultation between the board members the night before examinations are held as to the nature of the questions proposed appears to be a procedure that is needed at this time.

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### STATE NEWS ITEMS

*This department is supervised by Dr. Ralph N. Greene, Jacksonville. Members of the State Association are requested to forward to Dr. Greene or the Editor such news items as they may think of interest to the readers of THE JOURNAL.*

The Lee County Medical Society was organized at Fort Myers, November 26, and consists of eight members. The following officers were elected: Dr. J. C. Nowling, President, and Dr. Jones, Secretary. Dr. John S. McEwan, President of the State Association, addressed the society in a very enthusiastic manner. Drs. Adamson and Mason Smith of Tampa also attended the meeting and addressed the society. The State Association welcomes our newest society.

The Orange General Hospital at Orlando is carrying on an extensive building program, providing for a large central heating plant and a hundred bed addition.

The Orlando Clinic, Orlando, has moved into a new clinic building, located on Lake Eola. The following doctors are housed in the new building: Dr. John S. McEwan, Dr. J. S. Edwards, Dr. Meredith Mallory, Dr. J. A. Pines, Dr. H. C. Day, Dr. A. B. Whitman, Dr. L. C. Inghram, Dr. W. H. Spiers, Dr. E. T. Craney, Dr. W. H. Gwynn, Dr. M. M. Andrews, Dr. John Sinclair and Dr. William S. Sinclair.

Dr. W. W. Lassiter of Gainesville was a recent visitor in Jacksonville.

At the last meeting of the Duval County Medical Society the following officers were elected: President, Dr. Herman Harris; Vice-President, Dr. E. T. Sellers; Treasurer, Dr. Wm. McL. Shaw.

The following news item is forwarded from the Orange County Medical Society:



The Orange County Medical Society gave a banquet for Dr. W. C. Person, on the 21st of October, to celebrate his eightieth anniversary. There were present about thirty members of the society from Orange, Seminole and Osceola counties. Mr. W. R. O'Neal and Mr. N. P. Yowell, life-long friends and patients of Dr. Person, were also present around the festive board. Judge Wilbur Tilden, a son-in-law of Dr. Person, represented the family. The banquet was held in the club house of Dub's-Dread golf course. The event was very much enjoyed by all and we feel that in celebrating the eightieth anniversary of Dr. Person, who has spent thirty-six years in Florida devoted to the practice of medicine, the society which he helped organize in 1906 has honored itself in honoring him. Beautiful letters of commendation were read from Dr. Howard Kelly and Dr. J. Y. Porter, regretting their inability to be present on this occasion. Dr. Porter, strange to say, was celebrating his own birthday at home on this same day, being two years Dr. Person's junior. The staff of the Orange General Hospital presented Dr. Person with a beautiful cane to use should age overtake

him. Dr. J. H. Pines presided in the absence of Dr. H. Beardall and introduced Dr. J. S. McEwan, President of the Florida State Medical Association, who responded happily. Mr. Yowell and Mr. O'Neal spoke at length on the esteem and affection which they felt for Dr. Person and gave testimony of his ability as a physician and his worth as a citizen for this community. Dr. C. D. Christ made an eloquent talk on his professional life, and stressed his kindness toward the younger men of the profession while they were trying to get foothold. He presented the cane from the staff of the Orange General Hospital.

Dr. Albert E. Acker, a most esteemed member of the Duval County Medical Society, died in November. Dr. Acker was a general practitioner for many years in Jacksonville and during the World War served as a captain in the Medical Corps.

Dr. J. Brown Farrior of Tampa has just returned from a prolonged tour of the West. On the return trip he attended the Southern Medical Association meeting in Dallas.

## ABSTRACT DEPARTMENT

### SURGERY

Postoperative Intestinal Obstruction, Deaver, J. B. *Abstraction Medical Journal*, Vol. XXVII, Page 421.

Deaver, in a most readable article, shows the part peritonitis plays in both post-operative intestinal abscess and also in the production of the lesions for which the operation was undertaken. The lesions found are bands and adhesions due to the peritoneal exudate following inflammation of the peritoneum. In the early cases the obstruction is due usually to the sticking together of several loops of bowels. Obstruction follows more commonly an operation for acute appendicitis and usually because an abscess—often small—forms beneath the mesentery of the terminal ileum producing the agglutination.

The diagnosis must be made from an acute inflammation in some part of the abdomen other than that approached at operation; from a secondary abscess, and a paresis of the small bowels due to operation. He mentions perforation of

duodeval or gastric ulcers, acute pancreatitis thrombosis, gall bladder lesions, strangulated hernias which have to be excluded in making a diagnosis.

In all cases of recent laprotomy a history of attacks of intermittent abdominal pain we should think at once of intestinal obstruction and failure to do so early will result many times in a fatal end. It is far better to reopen an abdomen early and find no lesion than to delay and on opening find a mottled or gangrenous bowel with the presence of foul-smelling fluid.

As a precaution, at the primary operation carefully close all tears in the omenta and mesentery and where possible carefully cover all raw surfaces and search for and clean out abscess pockets.

The symptoms are intermittent cramp-like pains followed first by nausea and later by vomiting. Gastro lavage fails to relieve the vomit-

ing as long as it does in peritonitis and paralysis of the bowels and yields a dark foul-smelling fluid. In early cases the peristalsis is increased but later is diminished. Do not be misled by a bowel movement following an enema, for with the lesion in the small bowel we should at first get results from enemata. G. H. E.

### OBSTETRICS

Further Studies in Puerperal Infections and their Treatment. *American Journal of Obstetrics and Gynecology*, October, 1925. Vol. X, No. 4.

So many women are still dying from infection, that we should be willing to try out some of the numerous claims advanced to combat the bacteria in the blood stream. The author discusses the proper place of the three dyes, a acriflavine, gentian violet and mercurochrome 220.

Bacteria which reach the blood stream must be destroyed by an increased number of polymorphonuclear cells, or they will multiply, produce toxins and the train of symptoms familiar to us all. Therefore in every infection there is a mortal struggle between the bacterium and the leucocyte.

The normal woman resists ordinary bacterial infection because she has a reserve to combat, but she can not do this if her resistance has been lowered in any way. Therefore to combat the invasion we must either increase her natural resistance or we must put into the blood stream some chemical which can destroy the bacteria without injuring the individual tissues.

It has been claimed that the above mentioned drugs can do this. For final proof as to efficiency of any chemical introduced into the blood we must ascertain the following facts: First, the effect on red and white cells, fragility of red cells, on coagulation and bleeding time and effect or inability and phagolytic power of the leucocyte. Second, do these drugs give to the whole blood any bactericidal property not present in normal blood? Third, their effect on various body tissues. Fourth, cause of death in animals that die following a large dose of the drug. Fifth, can the injection of a nonlethal dose of the dye prevent death after the injection of a lethal dose of the organisms?

The author quotes statistics and animal experiments with these dyes by himself and others from which he draws the following conclusions: Neutral acriflavine is not a legitimate therapeutic measure in hemolytic bacteriemia. It is injurious to certain body tissues, especially kidney

and liver. It can be positively stated that mercurochrome has no beneficial effect but may be harmful. The author then endeavors to show the good effects following transfusion of 200 to 300 cc. blood combined with Ringer's Solution and acid sodium phosphate. Thus he restores the alkalinity and dilutes the toxins already present. Transfusion is applicable in those cases suffering from a toxemia without a positive blood culture, also in severe secondary anemias following an infection lasting several weeks, when it is absolutely essential to increase the patient's individual resistance. It is important that we do not wait too late to use the transfusion in any of these cases. S. R. N.

### DERMATOLOGY

"The Tubercle Bacillus as an Etiologic Factor in Lupus Erythematosus." *Archives of Dermatology and Syphilology*, Vol. 12, No. 5, Dec. 1, 1925.

The etiology of lupus erythematosus has long been a dermatological problem. The tubercle bacillus and its toxins are usually considered as causative factors when the subject comes up for consideration.

In this article by A. Benson Cannon, M. D., and George G. Ornstein, M. D., of New York, after a careful study of 23 cases of the disease, five of which cases are given in full, the following conclusions were reached:

"Tuberculosis, both macroscopic and microscopic, was produced in guinea-pigs inoculated with biopsy material from five of twenty-three cases of lupus erythematosus.

"This fact, while not conclusive proof, would point to the tuberculosis bacillus as the etiologic factor in this disease.

"The hypersensitiveness to tuberculin, general, local and focal, is suggestive of the tuberculous nature of this disease." J. L. K.-S.

### OTO-LARYNGOLOGY

Statistical Studies of the Children in the Chicago Public Schools for the Deaf, Geo. E. Shambaugh, M.D., et al. *Archives of Oto-Laryngology*, Vol. 2, No. 5.

The salient features of an article written after much detail work and recording of statistics may be best enumerated in a summary as follows:

1. The 290 child patients in three hospitals have that type of deafness known as nerve or internal ear deafness. Children deaf from correctable nose or throat troubles are not found in institutions.

2. Of the 290, 123 had their tonsils removed purposing to benefit a condition which could in

no way be influenced by surgery in the nose or throat.

3. Prevention of the deafness in any case of this type could hardly have been accomplished, for example: 25 of the acquired were due to meningitis—here nothing beyond general treatment would have influenced and in 14 due to scarlet fever Dr. Shambaugh believes no local treatment would have changed the end results. Of these 14 cases only 8 had associated otitis media.

4. Age. 115 gave onset before the fifth year and the remainder before ten. The early age due largely to occurrence in childhood of the infectious fevers destroying the internal ear.

5. Study and testing of patients. Exactly one-half were congenitally deaf and one-half had

acquired ear trouble. One-third of the congenital cases were classed as due to heredity. The large majority of the acquired cases were due to infectious fevers, meningitis ranking first, scarlet fever second. Of these 89 had no otitis media and 56 had otitis media. Twenty were unknown and 12 were syphilitic.

Total deafness existed in 58 per cent of the congenital cases and in 35 per cent of the acquired.

Vestibular responses were present in 75 per cent of the congenital cases and in 62 per cent of the acquired.

Total absence of the vestibular responses and total deafness were found in 17 per cent of the congenital and in 38 per cent of the acquired cases.

J. L. B.



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*Manufacturers of Infant Diet Materials*

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## THE ROLE OF CALCIUM\*

CARLOS F. ARROYO, M. D.,

Tampa.

In recent times the attention of physicians has been called to the important role played in many physiological and pathological phenomena by calcium and its salts.

Calcium exists in our tissues in two forms, according to Vines<sup>1</sup>; there is a combined calcium that plays an important part in the coagulation of the blood, and an ionized calcium which seems to be the form in which this element is absorbed by our tissues. Palmer<sup>2</sup> says that, aside from its importance in bone formation, together with phosphorous, calcium also plays a significant part in muscle contraction, cell permeability and regulation of blood sugar.

Oscar Loewe<sup>3</sup> says calcium plays a dual role in our organism, its functions being sometimes active and sometimes passive. Among calcium's passive functions he describes egg-shells and sea-shells and the formation of bones and teeth.

Among calcium's active functions we must consider its influence upon blood coagulation, upon heart beat, as a stimulant of the nervous system and the important part played by calcium salts upon the mechanism of secretion and excretion.

Voohoeve says calcium's importance in the organism is proven by its multiple functions and thinks that in all the varied vital manifestations as well as in all pathological phenomena, the behavior of the serum calcium should be borne in mind and investigated.

According to Pottenger<sup>4</sup> calcium has a definite action upon the regulation of the impulses of the sympathetic nervous system and it maintains the equilibrium in the cellular colloids. Its biochemical action seems to be antagonistic to that of potassium, which is in itself a stimulant of the vagus. According to this, the whole problem of sympatheticotony and vagotony would be reduced to the predominance of either calcium or potassium in the humoral fluids. It is not my in-

tention to go into minute details regarding colloidal cell activity, as I don't feel this is the place to treat of such a big problem. But, if calcium has a decided stimulating action upon the sympathetic nervous system, it is natural that it has also an important part in regulating the internal secretions.

Fisher and Riethmuller say that calcium increases phagocytosis and Taworski has seen that calcium possesses a definite action upon inflammatory processes.

Curber saw that weak solutions of calcium increase phagocytosis and the resistance of the tissues against infection.

Calcium is largely excreted by the intestines. The daily need of the body is probably 0.7 gm., but the ingestion of 1 to 1½ gm. daily is advisable to allow for non-absorption.

It is a proven fact, that can be observed daily in medical practice, that all long-standing intoxications produce a loss of calcium salts. Thus we see, for instance, in tuberculosis the periods of aggravation of the disease coincide with abundant phosphaturia and great loss of calcium. Many industrial intoxications are accompanied by bad teeth. All long-standing infections leave traces of their passage in the mouths of their victims. The well-known sign of Hutchison's teeth is proof of poor calcium metabolism. Constipation is almost always a companion to dental caries and tuberculosis. Wherever there is a focus of infection or of inflammation, we find a deposit of calcium. All of which tends to show that calcium plays a very important antitoxic role in the organism.

The enormous loss of calcium observed in chronic intoxications would seem to indicate that the toxins must combine with calcium to be eliminated. Thus the dental decay observed in pregnant women have as a cause not only the drawing on the mother's calcium reserves for building up the foetal skeleton, but also the furnishing of the necessary calcium to combine with the toxins resulting from the metabolism of the fetus. A proof of this can be seen by the beneficial action observed in eclampsia by an intravenous injection of calcium chloride.

The antitoxic function attributed to the para-

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg May 19-20, 1925.

thyroid glands rests in intimate relation with their action upon calcium metabolism, as the extirpation of the glands leads to a definite lowering of the calcium level and administration of calcium salts relieves the chief symptoms of parathyroid extirpation, namely, tetany.

According to Salvessen<sup>5</sup> tetany is due to calcium deficiency. We know that convulsions always form part of the symptoms of most intoxications.

The parathyroid glands seem to regulate the calcium level in the organism and provoke the absorption of this element when conditions require, thus the absorption of calcium is determined by the needs of the organism. This explains the paradoxal phenomenon observed by Manoussakis<sup>6</sup> who found, in tuberculosis patients, that the administration of calcium salts would increase decalcification.

The cases that fail to fix in their tissues a sufficient amount of calcium salts to meet their requirements should be considered cases of parathyroid insufficiency. In rickets, aside from the lack of vitamins, an insufficient parathyroid function should be considered. As a matter of fact, some endocrinologists, Maranon<sup>7</sup> among others, consider avitaminosis and endocrine insufficiency one and the same thing. As to the beneficial action of sun rays in rickets and tuberculosis, I am inclined to admit a stimulation of the parathyroid function. Sergeant<sup>8</sup>, after extended study of the calcium level in the blood of tuberculous patients, found in all cases of fibrous tuberculosis with good general condition, a hypercalcemia. The same results were attained by Looft<sup>9</sup> in Strasburg. It is a proven fact that in the production of a soil favorable to the development of tuberculosis, deep perturbations of the endocrine sympathetic system should be taken into account. In consequence, we may assume that the parathyroid glands should have a function, in regards to calcium, similar to the function of the pancreas in regards to carbohydrates. This hypothesis would lead us to admit the existence of a threshold of calcium tolerance different in each individual, depending on the condition of the parathyroids.

Another proof of calcium's antitoxic function seems to be the behavior observed in edematous patients when calcium is administered. Altho not all writers agree as to the mechanism and significance of edema, it seems to be that edema, as Aldrich<sup>10</sup> imagines, possesses protective and cur-

ative functions by diluting the toxins present in the cells, thus preventing serious toxic injury to the tissues. As soon as we administer calcium to an edematous patient, we see that the edema starts decreasing, which may be considered proof that the toxins, kept in dilution by the edema, have been neutralized, making hyperhydrosis unnecessary. It is true that calcium provokes diuresis and improves muscular contraction, both favorable to reabsorption of edema, but we have to admit that this alone may not be sufficient.

Spangler<sup>11</sup> has proven that the injection of an active toxin such as crotalin (snake venom), produces a series of symptoms all of which can be traced to a lowering of the calcium level in the tissues, lengthens the coagulation time of the blood and increases the elimination of calcium.

Numerous therapeutic conclusions can be drawn from the knowledge of the role of calcium. It is a long time since Ferrier proposed the use of calcium salts in the treatment of tuberculosis. Ferrier's proposal was merely based upon empirical facts with no scientific foundation, and still we must admit that his clinical instinct was not mistaken. We all have given, and are still giving, calcium salts to our patients.

Sergeant<sup>12</sup> applied Ferrier's system to 1,574 patients. He only could get a follow-up study in 306, of which 123, or 40%, improved in every way, no matter how far advanced their lesions were. Out of this 123 improved cases 41, or 14%, could be considered practically well after three years. 142, or 46%, improved in their general condition, gaining in weight although the local signs were not influenced. All of them showed lesions in the second or third stage when treatment was started. In 41 cases, that is 14% of the total number, the disease could not be checked.

I make a routine to prescribe calcium lactate and parathyroid gland to all my cases of tuberculosis. In some cases I also give intravenous injections of calcium chloride and I have obtained very remarkable results. The following history is typical of my cases:

Report—A waiter came to me complaining of pain in the back, a little cough, and he has seen blood in the sputum sometimes. His skin is pale and he has been losing weight. He blamed his loss of weight on the kind of work he was doing, namely, waiting on people. He said he had to walk several miles a day. On examination, evidence of tuberculous infection of both apices



was found. The diagnosis was confirmed by the X-ray. The conclusions on the report by Dr. Dickenson, dated September 2, 1922, were as follows: Findings suggest tubercular infection of both upper lobes, more extensive on the right, with evidence of small cavity in the right apex.

The patient did not want to discontinue work as suggested, so I limited myself to prescribe: Calcium lactate gr. 5, three times a day. Parathyroid gland gr. 1/20. Since his last visit, during a period of nearly two years, I saw the patient occasionally only. He said that he was feeling better and had gained in weight. On June 18, 1924, another X-ray was taken and the conclusions this time were: When compared with films made of this patient in September, 1922, there is a decided improvement in the appearance. At that time the right apex was densely clouded by an infiltration very much softer in character than that seen at this time, and I am of the opinion that the tuberculous process, which was believed to be active at that time, has become arrested. It is interesting in this case the fact that he did not discontinue his hard work for a moment.

The foregoing history is typical of the results obtained by me in the treatment of tuberculosis with the use of calcium. These results are in accord with those observed by others, especially the French authors, followers of Ferrier. Cheinisse<sup>13</sup> reports 200 cases of pulmonary tuberculosis that he has treated with intravenous injections of calcium chloride. The course of treatment consisted of two series of fifteen injections each, with an interval of ten days, the injections being given, as a rule, every second day and the average dose being 300 c.c. of 1½%. He also fed calcium by mouth. I think that it is not necessary to dilute calcium chloride as much as Cheinisse reports. My average dose is 10 c.c. of 10% solution, and Carnot and Blamoutier<sup>14</sup> have injected 2 c.c. of a 50% solution of the salt without discomfort to the patient.

The objections of Seelig<sup>15</sup> to the use of a concentration higher than 1%, I think, are grossly exaggerated and his arguments not convincing at all.

An important point in administering calcium salts to tuberculous patients is the proper selection of the compounds to be given. Ferrier already noticed that the insoluble salts of calcium seem to give better results than the soluble. Sergeant, following in Ferrier's footsteps, used the

carbonate and the biphosphate of calcium with the result that we already know. Most of the men treating tuberculous patients use calcium lactate, a compound of difficult solubility, but in modern times we have seen that the soluble calcium salts give as good, if not better, results than the insoluble ones. The most soluble and easiest handled of all calcium salts is, without doubt, calcium chloride. This salt is soluble in less than its weight in water, being deliquescent it never precipitates and can be given by mouth or intravenously. This latter being the method of choice. It seems to be readily absorbed by the tissues and probably ionized as soon as it reaches the blood stream, and its antitoxic and antiseptic action is most likely increased by the presence of the chlorine radical. As to the action of calcium in tuberculosis, I think, its favorable influence upon the disease depends from its action on edema, more than from its promoting of fibrosis. The absorption of focal edema hampers the living conditions of the infecting organism by altering the soil.

I have used calcium chloride in a case of eclampsia with lung edema with good results. In a case of uremia the action of calcium chloride was very interesting. It was an old man of 76 years, suffering from an attack of acute uremia. I reached his bedside while he was in deep coma. The history of long-standing kidney disease and the characteristic odor of his breath furnished me the diagnosis, which was confirmed by the chemical analysis of the blood. Hot packs were applied to his body and a strong physic of 2 oz. of compound tincture of jalap was administered. In addition to this an injection of 10 c.c. of a 10% solution of calcium chloride was given. Immediately after the injection the patient began to perspire freely and the kidneys to work to the extent that during the following twelve hours the patient passed more than two quarts of urine and was talking and asking for food. However, the patient died thirty days later because of the natural law that says that *restitutio ad integrum* can never be accomplished. I have used calcium chloride in many cases of lung congestion of various degrees and in all of them I noticed the patients start breathing normally after the injection, in spite of their having been gasping a few minutes before. In these cases the results persist for a few days and in some instances they become permanent.

Let us see what happens when an intravenous

injection of calcium chloride is given. As soon as the injection is started the patients complain of a feeling of heat all through the body, especially in the mouth. The skin flushes and sometimes before the injection is finished they are perspiring freely. There is a feeling of precordial oppression that in a few minutes gives way to a feeling of general well-being. Some of them feel thirsty immediately after the injection, but I never observed any unfavorable symptoms as result of the injection. On giving the injection, care must be taken that all of it goes into the vein, as the smallest drop remaining under the skin is sufficient to produce a painful burn that generally leaves an ugly scar.

I give calcium chloride in all my cases of kidney insufficiency and chronic colitis. In these cases I give it by mouth, well dissolved in syrup of orange peels. In giving calcium chloride by mouth care should be taken to see that it is well diluted as otherwise the patients will complain of a burning feeling in the stomach. This treatment may be continued for months at a time without any fear of complications. All the patients treated in this way have improved.

I have used calcium salts with good results in the treatment of hemorrhages, anemia, and urticaria.

Mosen<sup>16</sup>, of Moscow, treats tuberculosis of all kinds by intravenous injections of 15 to 20 c.c. of a 40% solution of calcium chloride. Petzetakis<sup>17</sup> associates calcium chloride, intravenously, to emetin for the treatment of amebic dysentery and its complications. Pottenger reports favorable results from the use of intravenous calcium chloride in three cases of asthma.

The complete review of all therapeutic uses of calcium would require volumes.

As to the physiological effects of calcium chloride, I think they can be defined as follows: general stimulation of the sympathetic nervous system with subsequent hypercrinia, increased diuresis, vaso dilation, which explains its favorable influence upon the healing of indolent ulcers, and an increased muscular activity with a consequent improvement of heart action and paristalsis.

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#### DISCUSSION

*Dr. Love, Jacksonville:*

There has been a great deal written in recent years concerning the function of calcium salts, most of which seems to have proven more or less untrue. At one time we believed that the deficiency of calcium was responsible, largely, for hemorrhage and for conditions simulating or bearing a close relationship to hemophilia or purpura.

We have found that the blood of even hemophiliacs is not deficient in calcium and have found that the administration of calcium will not in any way prevent or control hemorrhage. It is useless when administered for this purpose. When there is a deficiency of calcium in the blood, however, and if it exists for any length of time, we may feel reasonably sure of a tendency to osteoporosis or a condition of tetany. Osteoporosis, and possibly rickets, is not caused so much by a deficiency of calcium in the food as it is by the failure of the organism to synthesize the calcium that is in the food. For tetany we have an absolute specific—calcium chloride.

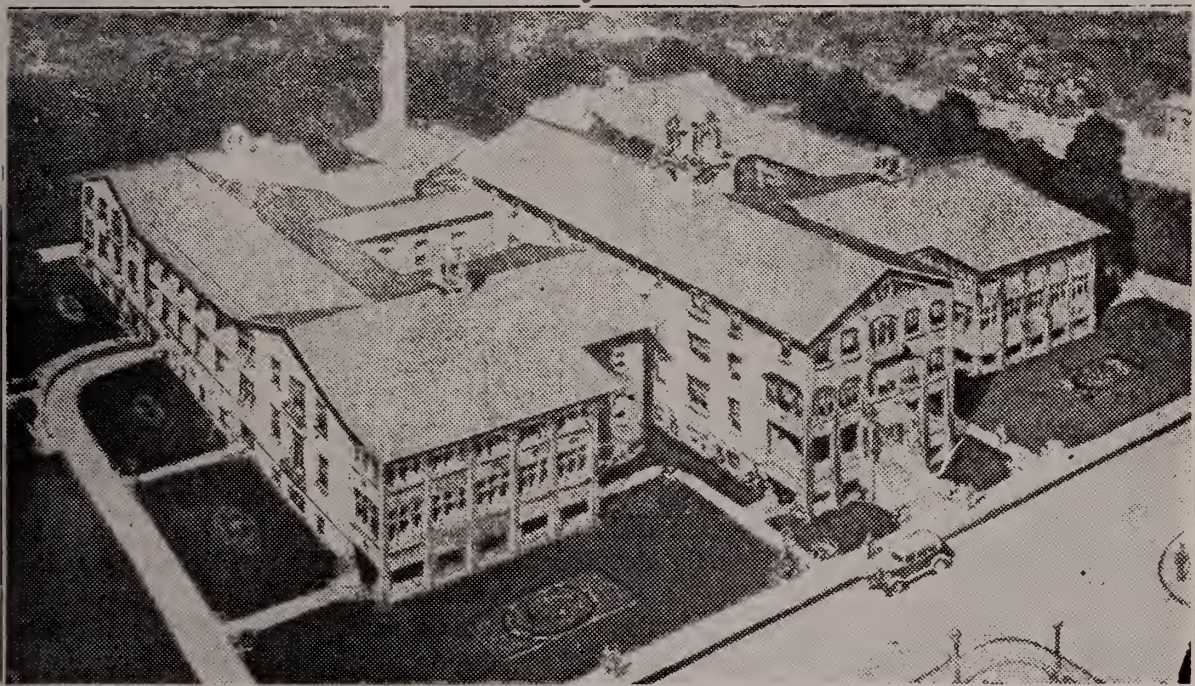
Calcium chloride cannot be administered subcutaneously without causing a considerable amount of irritation. Calcium lactate, by many authorities on therapeutics, is looked upon as absolutely without virtue.

#### CONCLUSION

*Dr. Carlos F. Arroyo, Tampa:*

I have nothing further to add, but wish to thank Dr. Love for discussing my paper, and the other doctors for their attention in listening to the paper.





DUVAL COUNTY HOSPITAL

IN THE NAME OF MERCY—A picture of the proposed county hospital which is now nearing completion on West Tenth street. The hospital will be under the supervision of Byron T. Thacker, manager of the Duval County Welfare Board, with headquarters in Jacksonville.

### THE DUVAL COUNTY HOSPITAL\*

R. H. MCGINNIS, M.D.,  
Jacksonville.

The writer of this brief history of the old and new Duval County Hospital has, after strenuous effort, secured information from many available sources, by written communication and personal interviews, and the data offered in this article is substantially correct, but he feels, however, in presenting this matter to the medical and surgical staff of the hospital, and the Welfare Board, his deficiencies as a narrator of facts and begs of the staff and board a conservative estimate of his endeavors.

The site of the Old Duval County Hospital was purchased in two parcels. The first, tracts 27 and 28 in northeast Jacksonville, known as Oakland, a subdivision, was purchased by the Duval County Commissioners without restric-

tions, by warranty deed, June 4th, 1870, and recorded the same day. The title to this property was established by a decree of the Circuit Court of Duval County on March 4th, 1903, and recorded the same day. Adjoining property, consisting of parts of lots 196, 197, 198, block 30, "Oakland", was purchased, without restriction, by the County Commissioners November 19th, 1910, and recorded December 2nd, 1910. The two parcels, surveyed by the County Surveyor February 8th, 1913, comprises 8 acres and the survey is recorded in the office of the Clerk of the Circuit Court for Duval County.

Eight buildings were erected on the above-mentioned site between 1870 and 1890. Records of the county being destroyed by fire, May 3rd, 1901, there is nothing accurate as to the year the present buildings were constructed. The writer, from hear-say evidence, is of the opinion that the buildings now occupying the site, with the exception of the operating room and tuberculosis camp, were built in the early seventies and desig-

\*Read before the Staff Meeting of the Duval County Hospital, November, 1925.



nated as the Duval County Poorhouse. Two of the buildings were of the pavilion type, of two stories each, one for housing white and colored females and the other for white and colored males. The six other buildings were of one-story construction. One for administrative service, another combined dining room and kitchen and the others for various utilities necessary.

The pavilions were equipped with cots and beds and necessary covering. Heat in winter, supplied by wood-stoves, which prevails at present. The inmates were the aged, infirmed and indigent. A caretaker provided food, laundry and help. A physician was called from the city when his services were considered necessary. Sewage and toilets, baths (tub and shower), gas and electric lights were installed in the early nineties. During the yellow fever epidemic in 1888, in Jacksonville, this institution was not used as a hospital for patients suffering from this disease.

Early in the eighteen nineties the institution began to assume the resemblance of a hospital. The County Commissioners, at this time, allotted to the lowest bidder, provided he was a physician, the care and maintenance of the admissions to the institution. The physician obtaining the contract provided food, attendants and his professional services. He made a monthly report to the County Commissioners and received from them a remuneration at a per diem per patient rate. This practice prevailed for a number of years and no surgery of any consequence was done in the institution.

In 1899 a young man entered the ranks of the medical profession of Jacksonville, opened an office and became the surgeon of a large lumber mill. This lumber company operated and owned a railroad to supply the mill with timber to be manufactured into a marketable product. He found the hospitals in the city inadequate to offer him beds and facilities for the care of the injured and sick of this company. Obtaining permission of the physician in charge of the Duval County Hospital to use the institution for these patients, he became interested in the care and treatment of the other patients in the hospital. This young surgeon, with the indefatigable temperament characteristic of the man, enthusiasm that has never wained and with energy that has neither faltered nor lessened, has contributed more to make the Duval County Hospital the efficient institution it is today than any other individual.

He and some of his colleagues operated under many difficulties, using a plain pine table placed in a back ward of the colored male pavilion, and an ordinary Arnold sterilizer for sterilization. They used short-sleeved gown and no rubber gloves, scrubbing their hands in basins of ordinary warm water and using the usual solutions of those days to secure sterility. Under these environments and difficulties these men operated upon many of the reparable conditions found among the patients and restored them to usefulness, happiness and contentment. All instruments, appliances, splints and apparatus used by these men were furnished and paid for by them.

Such conditions continued until 1913 when the Duval County Commissioners, after some urge, decided to operate the hospital. They secured the services of a superintendent, a graduate nurse, with power to engage what nursing help seemed necessary, to take care of the patients and manage the institution; and the expenses were paid by the Commissioners. During this year the present operating room and tuberculosis camp were constructed and equipped, and a staff of seven physicians selected to care for the medical and surgical service.

This staff organized, but met infrequently, nevertheless functioned with considerable credit until 1917 when many of them enlisted in the service of the United States in the World War. During this period of 1917, 1918, 1919, the hospital patients were directly cared for by a county physician, employed by the Commissioners, and indirectly by those of the staff who had not the opportunity to enter the service of the United States army and Navy in a military capacity. When the enlisted men returned from the army and navy their services were resumed in the hospital and continued until 1920 when the Duval County Board of Charities assumed control of the medical and surgical management. During 1920 the present staff was organized with five members as an official body, one member in each of the following branches: Medicine, Surgery, Eye, Ear, Nose and Throat, Neurology and Dentistry. During 1925 a separate neurologic department was discontinued and neurology placed under the medical department. An outpatient department was created and an official staff member elected on this service.

At this point it is well to record the birth, growth and development of the social service work in Duval County. This service was organ-

ized in 1910 under the name of Associated Charities, with a paid secretary and office force, receiving its sustenance and maintenance from voluntary contributions of its membership and the citizens of the city of Jacksonville. Various and sundry committees, from the membership, functioned in many capacities thru a board of directors until 1920, a period of ten years.

Associated Charities merged into a city board of charities, which operated on a larger scale of endeavor until 1921 when more extended effort became necessary and expedient, and the Duval County Board of Charities assumed the social activities of the entire county. This board of charities inaugurated many additional features to the expanding requirements of the service and functioned until 1923, a period of two years. It was deemed advisable, at this time, to do away with the word "charity" and substitute the word "welfare" for all activities along the line of social and rehabilitation work, and a measure was introduced and passed by the State Legislature of 1923 creating a Duval County Welfare Board, outlining its duties and prerogatives, and enabling it to ask the Duval County Commissioners to levy a county tax of three mills on the assessed valuation of the property of Duval County for its maintenance. The Welfare Board, realizing the handicap the medical and surgical staff of the hospital had in rendering competent and efficient service in the antiquated and fire-menace buildings comprising the hospital group, began devising ways and means to provide a new hospital building, modernly equipped and officered, under one roof, to enable the staff to do better work in its great rehabilitation program. It has been possible, however, with the old and inadequate buildings, to perform service therein which meets with the minimum requirements of the American College of Surgeons to admit the institution to an A-1 rating. It being admitted with an "asterisk" in 1922 and in 1924, it was accepted without reservations. This rating enables the hospital to appeal to the better class of graduates of medical colleges to accept it for their internship and clinical study. The hospital has had interne service since 1913. Intermittently during the first four years. No internes could be obtained during the years 1917, 1918 and 1919. Since then two internes have been secured each year and none of them have been dissatisfied with the service.

In 1916 the Duval County Tuberculosis Asso-

ciation obtained, thru its adherents and workers, a signed petition of 25% of the voters of the county, petitioning the Commissioners of Duval County to call an election for a referendum vote to enable the Tuberculosis Association to provide some means to care for the indigent tuberculous patients of the county. At one of the regular elections in 1916 the question was accepted by the people by an overwhelming majority. A measure was therefore prepared by two interested attorneys without remuneration, and presented to the legislature in 1917 and enacted into law. The measure provided for the creation of a tuberculosis commission, consisting of three members, to carry out the requirements of the law. The necessary funds to enable the commission to function was a one mill levy on the assessed valuation of the taxable property of the county. Two physicians could have received appointments on this commission, but the members of the Duval County Medical Society, being modest and wishing not to offend, only recommended one physician to serve with two laymen, also recommended by the society. The recommended commission was appointed by the Governor of the state. Any county or group of counties in the state were authorized to operate under this law. The Duval County Tuberculosis Commission organized and the physician-member was chosen chairman. An architect was selected and plans and specifications for a fifty-bed tuberculosis hospital, on a site previously purchased by the commission, consisting of  $2\frac{3}{4}$  acres, more or less, at the intersection of Tenth and Surveyor Streets in northwest Jacksonville. Contract for the building was let in June, 1922, and final payments were made in September, 1923.

It is to be recalled that the Duval County Welfare Board, by law enactment, removed the necessity for a tuberculosis commission and the commission relinquished its books and turned over its funds to the Welfare Board July 1st, 1923.

The Duval County Welfare Board was organized in July, 1923, pursuant to Chapter 9274, Laws of Florida, Acts of 1923. The Board immediately authorized an architect to proceed with plans for additions and alterations to convert the former Tuberculosis Hospital into a general hospital for the treatment of all diseases, including tuberculosis. In August, 1923, the constitutionality of the law creating the Duval County Wel-



fare Board was attacked in the Circuit Court for Duval County, Florida. Five public-spirited lawyers, without charge, represented the Board at the hearing before the Circuit Court. The Circuit Court promptly declared the law valid and dismissed the suit. However, the attack was renewed by appeal to the Supreme Court of Florida. The same lawyers represented the Board before the Supreme Court, without charge. The Board was again successful when the Supreme Court handed down an opinion sustaining the validity of the law under which the Board was created. All work on the hospital was discontinued during the pendency of this litigation, for obvious reasons. This caused a delay of between six and seven months. Immediately after the Supreme Court's decision the Board proceeded with its plans for remodeling the tuberculosis hospital. In the latter part of July, 1924, contracts were awarded for the construction of the new building and the remodeling and alteration of the old one. The original tuberculosis hospital cost in the neighborhood of something less than \$150,000. The new building and remodeling of the old one represented an additional amount of a little over \$200,000. The whole work was completed in October, 1925. The building is a fire-proof structure. During the fall of 1925, the Welfare Board has planned and purchased equipment for the entire building, representing an expenditure of something less than \$75,000. At this time, November, 1925, the equipment is being installed, and suitable and efficient management of its hospital and social service activities are being provided.

The Duval County Hospital of 186-bed capacity, to be opened and ready for service in the next few months, is a county institution, built, equipped and maintained by the citizens of the county, thru taxation of a three mill levy, for the express purpose of caring for the indigent sick of the county. It is the earnest desire of the Welfare Board to render the very best service to the unfortunate citizens of the county who may have to appeal to it for assistance, and to carry out this laudable, sincere and worthy motive, the hospital and social work of the Board should not be burdened with the citizens of other counties of this state and other states seeking its assistance and aid. Any county, or group of counties, may operate a hospital under the same law which governs the activities of the Welfare Board of Duval County.

## ROENTGEN DIAGNOSIS AND BRONCHOSCOPIC TREATMENT OF LUNG ABSCESS\*

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and

W. McL. SHAW, M.D.,

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The purpose of this paper is to present the Roentgen diagnosis and results of bronchoscopic treatment of lung abscess with observations and inferences on certain phases of the subject.

Abscess of the lung occurs under the following conditions: Following operations, especially those of the nose and throat, and neck, tonsillectomy taking the lead; following foreign bodies of the lung; ether anaesthetics, especially in T. B. and childbirth; following acute infectious diseases, especially whooping cough, measles, and scarlet fever; following influenza and pneumonia; and secondary to embolic or so-called metastatic abscesses.

As to the locality, the majority of the cases occur in the right lung; the lower lobes being far more affected than the upper ones. The roentgenologist is essential here, for he furnishes us exact knowledge as to the location and extent of the lesion.

The duration of the lung abscess may date back several weeks or many years. Forty-four years is the longest seen in Jackson and Moore's series in Philadelphia, while twenty years is the longest period seen in our series.

The rareness of spontaneous recovery from lung abscess can be readily seen and determined by the number of cases one sees during a year, that have been going from doctor to doctor receiving no relief and steadily growing worse.

Free drainage is always fundamental for supuration anywhere, and it is with this purpose that bronchoscopic aspirations and irrigations are applied to lung abscess cases. The means of improving drainage are in the removal of obstructing granulation tissue, the dilation of stenosed bronchi and the restoration of ciliary action by aspiration of areas of purulent drowned lung. The readiness with which a patient returns for further treatment, sometimes unsolicited, is the best evidence of the relief obtained. Before the treatment is begun, all details of the diagnosis

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\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg May 19-20, 1925.



from the internist's, the surgeon's and the roentgenologist's standpoint are gone into.

The treatment is as follows: The patient is allowed no food for six to eight hours previous to the operation; one hour before operation, he is given a hypodermic of  $\frac{1}{4}$  grain of morphine; ten minutes before operation, the larynx is anesthetized with 4% cocain. Up to the present we have never found it necessary to use other than a local anæsthetic. This is particularly fortunate, because the condition requiring our interference almost invariably contraindicates a general anæsthetic. The laryngoscope is first inserted and the vocal cords located; the bronchoscope is next introduced between the cords into the trachea and so down into the right or left bronchus, depending on where the abscess is located. The condition of the mucous membrane of the tracheo-bronchial tree is noted as the bronchoscope is inserted. As the abscess is reached, uncontaminated specimens of the secretion are taken either by swab through the bronchoscope, or, if the quantity is sufficient and not too viscid, the collection is made by aspiration into a specially devised tube, which can be immediately sealed and sent to the laboratory. The cavity is now thoroughly asperated and then irrigated with a phenol-lugol-normal saline solution. Bronchoscopic treatments are given every seven days in the beginning, autogenous vaccines are given twice a week; the patients usually remain in the hospital about one hour after treatment and then go home. Several of our patients work every day except the half day they take off for treatments. Normal rest, nourishing diet and postural change are also adjuncts to the treatment. Frequent X-Rays are made to complete our studies.

Bronchoscopy is contra-indicated in cases of profuse hemorrhage, in a moribund patient, in very extensive disease of lung tissue involving one-half or more of the lung, in far advanced diseases of the heart and great vessels and in laryngeal tuberculosis.

You are now asking yourself what dangers are attached; the dangers are practically nil; no deaths have been reported from reputable clinics. In our series of cases, no one has suffered any untoward effects and all have been helped. An analysis of our cases, including those complicated with bronchiectasis, in percentages, is as follows: 24% cured, 60% improved, and 15% unimproved. The improved cases are those which

have been greatly benefited and on whom we are still working and hoping for a cure. The unimproved cases are those patients with extensive bronchiectasis.

Of course, the earlier a case is seen, the greater the chance for cure. Patients are always willing to continue treatments, as long as we deem advisable, because of lessening of cough and foul expectoration and improvement. We have yet to see a patient who declined further treatment because of any dread of a repetition of the bronchoscopic treatment.

Bronchoscopic treatment of lung suppuration is, in principle, not new, but very old. The only new phase is in the development of the instruments and technique to the point where the lung can be drained by insertion of the bronchoscope through the mouth into the suppurating lung harmlessly, painlessly and in a very short period of time.

Let us now inquire in what manner a lung abscess reveals itself by Roentgen study. Its earliest stage can best be observed in the case of acute or aspiration abscess, the chronic or post-pneumonic type usually has a more insidious onset and, consequently, is not always suspected for some time. It is misleading to always think of lung abscess in terms of a cavity. Such is not the case. Jackson, of Philadelphia, characterizes the condition most frequently encountered as "A circumscribed area of lung tissue bathed in pus." In the acute type, if X-Ray examination follows even a few days after onset, there will usually be found a loss of density of varying size, surrounded by an area of increased density. The chronic type is characterized usually by a loss of density or cavity, single or multiple. The gradual development of a fibrosis in this area of consolidation coincident with repair, is revealed best by repeated Roentgen studies.

In the portrayal of these changes back to normal, the Roentgen examination can render us invaluable service. It accurately shows the extension or recession of the diseased area; it notes the existence and development of abscesses in situations inaccessible to physical examination, also providing the only definite information as to the complete cure of the patient. By an accurate localization of the abscess, it guides the surgeon or bronchoscopist in the precise application of his operative procedure.

How can all this information be secured by Roentgen examination? The answer is, by very

careful, oft-repeated studies, using many films and different positions of the patient. We feel that stereoscopic films are imperative here, as only in this way we can feel sure of the relative depth in the lung tissue of a small abscess. Films should be made in the usual standard positions, and, besides, often in the oblique and even lateral postures. The faster they are made, the more lung markings they show, and, consequently, afford more information. We have been using for the last two years a relatively low voltage with a high milli-amperage of 100 plus, at from one-tenth to one-fifth second, using a distance of about 30 inches. This gives you a sharp film of excellent detail. The importance of making these films stereoscopic can not be overemphasized.

Repeated studies, following the course of the disease after treatment has been instituted, we feel, are important, as it furnishes us with the only sure method of keeping in touch with repair or extension. Exacerbations sometimes occur which can best be studied by this method. With increasing chronicity of the abscess, the fibrotic tendency of the pneumonic infiltration increases, and it is here that secondary bronchiectases are formed.

In the differential diagnosis of chest conditions, one fundamental requisite is outstanding: It is necessary to correlate the X-Ray findings with the clinical symptoms, in all instances, before a definite diagnosis can be made.

For a diagnosis of lung abscess, we have to differentiate the evidence on the film from the following conditions: Small, encapsulated pleural effusions; localized, thickened plura (especially interlobar) following an empyema; some neoplasms; tuberculous cavities of the lung; actinomycosis and other fungus infections.

We have attempted to show that the Roentgen examination, properly done, is qualified to supply the clinician with valuable information in regard to the diagnosis and prognosis of lung abscess, and also, at times, to point the way to intelligent treatment.

#### DISCUSSION

*Dr. H. M. Taylor, Jacksonville:*

The subject of lung abscess is a most interesting one for the general practitioner, internist, as well as the bronchoscopist. Dr. Knaur's paper deals entirely with the bronchoscopic treatment, but it may not be amiss to state that every case of lung abscess will not respond to bronchoscopic treatment, for a lung abscess in the periphery in

some instances is a case for the general surgeon.

For a correct diagnosis it requires the cooperation of the internist, roentgenologist, as well as the bronchoscopist. I believe Dr. Shaw will agree with me that there are cases which the roentgenologist is prone to call a lung abscess which in reality is a tubercular cavity.

It is interesting to know that though Dr. Knaur has been in our midst but eighteen months, he reports so large a series as twelve lung abscesses. I doubt if many long-established bronchoscopic clinics in America have had so large a series.

It is also interesting to know that Dr. Knaur reports 24% of his series cured within eighteen months' time or less, even though the best authorities in the country state that a lung abscess cannot be pronounced cured, no matter how much improvement is manifested, under two years.

*Dr. D. R. Kennedy, Sarasota:*

I would like to say, in defense of Dr. Knaur, that I think this is an unusually good paper, and I believe the reason he has found these lung abscesses is because he has looked for them.

Dr. Thomas McRae had a clinic at one time in Jefferson, while I was a student, and he stated that we only found what we looked for. He showed several cases of lung abscesses. It had been, it seems, that they were having quite an epidemic of pneumonia in February and March; so he had a nose and throat man to direct this clinic, or to speak at the clinic, regarding these cases of lung abscesses, and the point was brought out that it was very easily overlooked, clinically. Just as a safety pin sticking in the bronchus blocks off an area as large as a lung abscess, which should be diagnosed, but is not diagnosed because it is not looked for carefully enough. Too many of us when we examine a chest or heart, do it through coat and vest, or hurriedly ask them to hold open the coat and let you listen to the heart, and then give an opinion on it. Whereas, if we had them strip off all clothes and go over them thoroughly, we would find a lot more of them.

*Dr. J. W. Taylor, Tampa:*

I would like to ask Dr. Knaur about the difficulty in introducing his bronchoscope to the abscess if it is more to the periphery than the center, and if these cases are not the ones that don't clear up so readily.

I also want to substantiate what Dr. Taylor said in regard to the few cases of lung abscess. I was talking to one of the X-ray men a few days ago and we were speaking of lung abscesses. He said that he had only seen three in the past year. I do some bronchoscopic work, not very much, and in the last five years I have only come in contact with three cases of lung abscess.

*Dr. Beals, Jacksonville:*

It has been my not unmixed pleasure to watch some of these treatments carried out. To me it has seemed like a most distressing procedure; to see them lay the patient on the table, stick a long tube down his throat and watch the patient struggling so much. But the most striking factor about this work, or any work of this nature, is the frequency with which these patients get off the table and give a negative reply when asked if it distressed them much, and then come back many times for further treatment.

So far as X-Ray work in conjunction with this condition is concerned, it is often quite valuable, although not so much in making the diagnosis. The diagnosis is usually made rather readily from the signs, symptoms and complaint. If the patient has been operated on and has not done well, but has developed a foul expectoration, or if the patient has had pneumonia and did not recover in the usual length of time and later had a foul expectoration, with a septic temperature, the diagnosis should be evident. The X-Ray is of inestimable value in locating and localizing these suppurative conditions of the lung which are often grouped under the head of lung abscess.

#### CONCLUSION

*Dr. W. McL. Shaw, Jacksonville:*

It does look unusual that we found twelve lung abscesses. However, from the X-Ray point of view, we have been seeing them for years. It is difficult to differentiate between conditions of this kind from the X-Ray point of view, but when we have somebody to go down and get pus, then we know we have an abscess. I think that is the reason why we see so many more now than formerly.

As far as the X-Ray goes, all chest X-Ray work has to be done in cooperation with the internist. You have to take into consideration your history, your clinical findings, and in the end your X-Ray findings before diagnosis can be made—this is very true of lung abscesses. You see a large cavity at times and don't know whether it is a lung abscess or a tuberculous cavity. Go into the history, sputum examinations, and guinea pig inoculation, and then you will know what you are dealing with. Differential diagnosis is very difficult. We do not want to create the impression that this is an easy thing at all. It is one of the most difficult things the X-Ray man has to decide, because the buck is generally passed up to him.

I feel like Dr. Knauer says, if we look hard enough we are going to find more than we have formerly. No one could take a peanut kernel or grain of corn, etc., out of the bronchus until Dr. Chevalier Jackson devised something to get it out with, and then we found lots more than we formerly knew we had.

*Dr. Knauer, Jacksonville (concluding):*

I just want to thank these gentlemen for their kind discussions.

As to the diagnosis: We have been very careful, going into it with the surgeon, the internist, the roentgenologist before starting the treatment.

In regard to the number of cases which Dr. Taylor has spoken of: I may have given the wrong impression, as all of these did not come from Jacksonville. I should say that about one-third of them came from other parts of the State.

The treatment of lung abscesses at the periphery is a debated question between the surgeon and the bronchoscopist. It is a matter which has to be decided in each individual case. It is always wiser, I think, to try the bronchoscopic treatment first in these peripheral cases, and then if you do not get results, try surgery.

In the majority of cases we have been very careful to get sputum and inject a guinea pig, wherever possible, to positively rule out tuberculosis.



DOCTOR GREENE RETIRES AS DIRECTOR OF ST. LUKE'S HOSPITAL,  
JACKSONVILLE, FLA.

Some three years ago Dr. Ralph Greene of Jacksonville, Fla., undertook, under conditions of personal and financial sacrifice, and as a duty to the profession and to the community, to reorganize the affairs of St. Luke's Hospital, Jacksonville.

Mr. Richard P. Daniel, President of the Duval County Welfare Board, recently stated that the results achieved in the reorganization of St. Luke's Hospital are without parallel in Duval County.

In the beginning of the reorganization program St. Luke's Hospital was seventy thousand dollars in debt, had had practically no repairs or replacements in a period of ten years and was occupied to only fifty per cent of its capacity.

At the present time St. Luke's Hospital has been painted and renovated throughout, has a definite sanitary program, in which is compiled the care of a large number of communicable diseases in a modern isolation hospital in which not a single case of cross-infection has occurred and from which communicable disease has not been spread. There is a modern and complete equipment, thorough renovation and repair of the physical plant, including the telephone and steam heat system. St. Luke's Hospital has a full-time laboratory and X-ray service and a special eye, ear, nose and throat operating room, a special Urological department, two main operating rooms and a standardized training school. The seventy-thousand-dollar indebtedness has been overcome and there is a surplus of some fifteen thousand dollars in cash in the general operating fund, in addition to which there is a fund of approximately sixty-five thousand dollars in bank, which provides for the payment for the construction of the new and modern children's and maternity ward which is about to be completed and which will represent the highest type of its department in the community.

The hospital is filled to capacity and its turning away as much patronage as it is able to receive.

Doctor Greene, having completed the reorganization program, will devote his entire time to the private practice of neurology.

A STUDY OF ACCESSORY NASAL SINUS DISEASE\*

L. C. INGRAM, M. D.,

Orlando.

This study was suggested at a time when I was searching the literature for a certain anatomical location in the nose. The object of this paper is to present the condition or factor I believe to be most vitally responsible for infections and inflammation in the accessory nasal sinuses and the relative frequency of such disease. The facts I shall present are generally well known, and my plan is to present them in a manner to be considered by a mixed society as represented in the Orange County Medical Society.

There are two names usually used to designate these sinuses: Accessory nasal sinuses or paranasal sinuses. A search was made through the literature presented during the past ten years for two national oto-laryngological societies. There were about fifty articles dealing with either one or all the accessory nasal sinuses. Only a small number of these articles considered in part or entirely the etiology of sinusitis, far the greater number discussed measures for the relief of cure of the sinusitis. The earliest description of the accessory nasal sinuses considered the maxillary sinus only, and was at the time named Antrum of Highmore, in honor of Dr. Nathaniel Highmore, the first to definitely describe it. Dr. Highmore was an instructor at the University of Salerno, Italy, and in his book, published in 1651, described this one nasal sinus which has carried his name for almost three hundred years. The earliest description of diseases of the sinuses considered the antrum also, and was the teaching of another Italian, Dr. Bruno. Dr. Bruno had been educated at Salerno, but at the time was teaching in the great medical school at Padua, Italy. He described the disease and a method of treatment, which was to pull a tooth and allow the sinus to drain. For our present knowledge of the anatomy of the paranasal sinuses and the pathology in the main, we are indebted to Zukerkandl, Swartzie and Hajek. Hajek has been the master for the last forty years.

The reason I have mentioned the source and development of our anatomical knowledge of these sinuses is because anatomical defects, established or in development, constitute the great-

\* Read before the Orange County Medical Society, Orlando.

est predisposing cause producing the disease under discussion. It is an accepted fact in medicine that the strength or weakness of an organ depends primarily on perfection of anatomical structure and the fact whether it has normal or abnormal development and relation.

In this study it seemed to me that there were two factors which were directly the cause, or contributing cause, of sinusitis: first, the anatomical and second, body reaction or susceptibility.

In an anatomical study we first consider the type. The type is determined, first, by race, and second, by family characteristics. We have types of noses which meet every requirement for function, and would maintain health of its parts unless some other factor defeats the purpose. The broad, open nose gives perfect drainage and ventilation and conserves the health of the sinuses. The high, narrow nose is the reverse, and all people of this type constitute the greater percent of sinus infection. The articles of Mosher, of Boston, in his observation of animal skulls, and a study of the Harvard clinics comparing different races and types, concluded that a nose which had a width of only 70% of height was predisposed to sinus trouble. He found the wide, open nose of the negro, and other races of a wide nose, were comparatively free from this disease, except that resulting from systemic infection.

Abnormal relation or development of organs, or structure within the nose, constitute another anatomic factor. Whenever these relations interfere with ventilation or drainage from the sinuses, it predisposes the sinuses to infection and inflammation.

In this group of anatomical defects which interfere with proper nasal breathing, ventilation and drainage, the following can be mentioned: The vestibule, or entrance to the nose, may be very small and under-developed or the result of depressed ala, or anterior curve in cartilaginous septum. The choana narium likewise may be so small or obstructed by growths or contractions on side walls as to interfere, even prevent nasal breathing. The septum or central partition may be so thick, bent and twisted, or contain spurs or a ridge that one or even both sides of nose is blocked. A not infrequent condition is for one of the turbinates, usually the middle turbinate, to contain an ethmoid cell and be so distended as to produce deformities of other structures inside the nose to give it space. The

soft parts may be enlarged or swollen permanently as the hypertrophies on turbinates or the hyperplastic swelling. Any of these conditions, or what is most usual a combination from these conditions affecting nasal respiration, is the foundation for some one or a combination of sinus infections. It is a fact that so many times there is more than one single sinus involved in the infection. Age is also a factor anatomically to be considered. At middle age, or past, if these deformities inside the nose have not produced sinus complications, it is reasonable to conclude that some form of compensation has taken care of the individual and that he will be less susceptible to the disease. Embryonic and post-natal development are a very important factor. We are taught the child is born, normally, with only two sets of sinuses—ethmoid and maxillary.

Many problems arise during this period, due to whether development of the sinuses have been over or above normal. The ethmoids migrate from their original position forming other sinuses, as frontal, and may take up abnormal positions as was mentioned in middle turbinate or occupy positions less likely to drain and most inaccessible for treatment. It is, I believe, a fact that the child has an acute infection of the accessory nasal sinuses more often than the adult, all as a result of some disturbance during development. This is, I know, contrary to the opinion held by the general profession. The research work of Skillern of Philadelphia, Dean of Iowa City, Carmack of Denver, and others in recent years, places some very valuable information in our hands concerning the relative frequency of sinus infection in children.

Men trained in this special branch of medicine and surgery see many cases, in children, of neglected sinus disease. Many times patients have been operated on for tonsils and adenoids and have not made satisfactory progress; in fact, sometimes they seem worse. Some of the sinus cases have recovered after this operation, relieved of infection in these organs and better nasal drainage after removing obstruction. Too many times unskilled hands did the operation and injury of epipharynx periosteal tissue over atlas or eminence protecting ostem of eustachian tube and matters made worse. Less surgery, and certainly less radical surgery, is indicated or really required in children to clear up abscess in the sinuses as would be necessary in the adult. However, the indications are that not enough of the



sinuses of children have been operated as they should.

Children with underdeveloped sinuses are more susceptible to sinus infection than any other. The reason for this may be due, I will admit, to the factor which has been responsible for lack of development of the sinus.

There is another factor, at the age of adolescence, that is responsible for drainage and ventilation disturbances and sinus infection—the active erectile tissue of the nose. This is an exceedingly common cause for sinus infection and usually overlooked. The cause of the child's illness, too frequently placed on tonsil and adenoid trouble, with a result much as has been described. Second, after the anatomical factor is the body susceptibility to other substances which enter the body and produce a reaction. Our latest term for this is *allerga*. The medical profession have known for many years that certain individuals were very susceptible to certain substances and would be injured or possibly lose their lives if given even minute doses. The reaction has been designated by different terms through the stages of development and study of this phenomenon. First, *idiosyncrasy*, *hypersensitiveness*, *anaphylaxis*, *allerga*. The primary reaction of an allergic individual, after coming in contact with an exciting agent, are manifested by local symptoms. The contact may produce, however, a more general reaction and even death follow the entrance of a very small amount of allergic substance.

Recently a classification of these substances has been made, putting all in three groups. Group one containing air-borne substances, pollen, dust, etc. Group two, substances which are regularly taken as foods or medicines, and third, the bacterial group as in focal infections.

We are interested in the local reactions from these substances, as they occur in the nose by far the most frequent form. The next in frequency is the reaction in the tracheo bronchial tree, usually called *asthma*; another, of course, is the skin. The most recent accepted term to designate this reaction is *allergic reaction*.

*Vasomotor rhinitis* may mean more than this reaction in the nose, but, I believe, is the most accepted term today rather than the unassociated term *hay fever*, used in general practice.

The condition of the nose, a part of the time during the attack, is anything but functioning.

Drainage and ventilation are suspended, the accessory sinuses are filled and then another stage enters, that is infection. Or there may be developed a permanent swelling, a *hyperplasia*, usually starting in the sinuses, most often the maxillary. Another stage may develop, a nasal *polypus*.

I have briefly described a disease affecting many thousands of people who are consulting the medical profession every day for relief. Men in general practice see them and men in special practice see them. We must avail ourselves of the knowledge available, in diagnosis and treatment, and give them relief. The clearer, better knowledge now available on the subject permits of much better success than was met in the past.

We now know that a proportion of *asthma*, *bronchitis*, so-called *hay fever* and *eczema* cases, that for so many years were studied unassociated, are really different manifestations of a common disease. They are the allergic reaction in susceptible individuals and require a common method for diagnosis and general treatment.

There is another factor I must bring into this classification under infection, and that is *abscessed root sockets*. The impression among men in general practice is that this is responsible for most maxillary sinus infection. This is not true. *Aveolar infection* is an important factor not as we usually think of focal infection, but more direct infection, either from the diseased root in the antrum or lymph stream or continuity of tissue. Rhinologists do not seem to be agreed as to what per cent of maxillary sinus infection is caused from infected teeth. Dentists claim as high as 90% maxillary sinus infection due to gingival and *aveolar* infections. Some of the most eminent *oto-laryngologists* think of the infection almost entirely descending, and as low as 20% from oral infection. In a recent article the author gives the percentage at 50-50 as ascending and descending infections. All are agreed that any *abscessed root socket* should be taken care of when we begin treatment of the sinus infection. The dentist and *oto-laryngologist* must work together.

Briefly, now, in summing up, I may say that in this study I have mentioned two groups of agencies responsible, directly or indirectly, alone or collectively, for accessory sinus infection and inflammation. The first are types predisposing



and, second, deformities in development or acquired, which defeat function.

Second reactions manifested in the nose, the allergic reaction of one of the three sources: air, food, bacteria, reacting systematically, but apparently a local expression in the nose. This again defeating function and responsible for a disease in the accessory nasal sinus.

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### CASE REPORT: UTERUS ACOLLIS WITH ATRESIA

SCOTT R. EDWARDS, M.D.,

Miami Beach.

A sixteen-year old colored girl, with a congenital anomaly of uterus acollis with atresia, associated with delayed puberty and amenorrhea, with ultimate hematometra and unilateral hematosalpinx. Her chief complaint was terrific recurring pain in the lower abdomen for the past four months at irregular intervals. The pain had remained similar in character, but gradually increased in severity.

Physical examination revealed a rather slim, anemic-looking child, very poorly nourished, with a marked ovoid swelling of the abdomen. The vaginal introitus admitted two fingers easily. However, there were no external signs of infection visible. The vault of the vagina was occu-

pied by a smooth, even, rounded mass, with absolutely no evidence of a cervix. A most careful inspection failed to reveal even the slightest suspicion of a dimpling, which might be expected as a cervical remnant.

These findings, furthered by bi-manual palpation, revealed very marked uterine contractions which corresponded in time with the subjective pain. An incision, under local anesthesia, into the bulging mass occupying the vault of the vagina, liberated a gush of accumulated menstrual blood. A rubber tube, one-half inch in diameter, was introduced into the opening, and the patient was allowed to go home with instructions to return within a short time, at which time it was contemplated doing a plastic procedure to maintain the opening in the uterus.

The patient disregarded this advice, and when next seen, after a lapse of about five months, she was in practically the same condition as originally. In view of the lack of cooperation, it was decided to do a hysterectomy, and eliminate any further recurrence of the condition. A mid-line incision revealed a greatly enlarged uterus bicornus. Enlargement, however, was limited to the right horn and right tube. The uterus and tubes were dissected free down to the vaginal walls, and detached from these by a circular incision. The vaginal vault was closed by a purse-string closure. The patient made an uneventful recovery.

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## Looking Backward Over Fifty Years of Health Work in Florida

JOSEPH Y. PORTER, M.D.,

*Former State Health Officer of Florida.*

1889 - 1917

*Serial No. 7.*

In chronicling the health history of the state it should not be assumed that there have been no dark spots, no perplexing incidents, no embarrassment of business, occurring in the past fifty years, or within the memory of the writer, whose memory of events dates back considerably beyond the period mentioned. Yellow fever had always been a curse to the health interests of the South, and that dark cloud had hung over the seaport towns of the state as far back as recollections can be recalled. Each summer season brought a dread of appearance of yellow fever,

because of the nearness of Florida to Cuba, and the citizens of the southern part of the peninsula lived in their trunks each summer season. Reed and his associates developed the thought of Dr. Carlos Finlay as to propagating cause of the disease. Since 1902, after the cause and means of transmission of yellow fever had been proven by Reed, the fear of yellow fever has entirely disappeared. It is recalled that yellow fever was almost of yearly occurrence at Key West. The disease was introduced by trading vessels and non-immunes, who had contracted the fever in

Havana, only to have the disease develop after reaching one of the seaports, by a vicious cycle of transmission soon set up an epidemic which attacked everyone, children and negroes, as well as adult whites who had not previously experienced an attack. Strangers (and the disease was known in the early days as "strangers' fever") were generally the fatal victims; children having the disease lightly, acquired an immunity to any future attack which time and experience proved was lasting in its protection.

Before leaving this most interesting subject mention should be made of just how an important medical scientific discovery of the nineteenth century was made possible. The destruction of the Battleship "Maine" in the harbor of Havana, on the night of February fifteenth, 1898, whether by external or internal explosive forces, brought about a condition which caused a rupture of friendly relations between the United States and the Spanish Government, quickly followed by a declaration of war by the United States. A battle between a giant and a pigmy took place in Manila Bay early in May when the Spanish fleet therein was captured in a bloodless struggle to our Naval forces. This incident was quickly followed the next month by the total destruction of Cervera's fleet as it emerged from the harbor of Santiago, with but a single fatality to our men. The battle of San Juan Hill at which it is said the colored troops of the United States fought bravely and saved the day for our forces, terminated the "Opera Bouffe" feature of the Spanish-American War. The tragedy of the conflict may be seen in thousands of headstones in many cemeteries of this country, of boys who died in Military Camps from typhoid fever, testifying in mute language to appalling ignorance of preventive medicine, hygiene, and sanitation. With the evacuation of the Island of Cuba by Spanish Troops, the American Army was left in charge, and Colonel Ludlow of the United States Engineer Corps became Commander of the western end of the Island, which included Havana. Colonel Wood of the Rough Rider Volunteer Regiment was given command of the eastern end of Cuba, with headquarters at Santiago. It is unnecessary to repeat what has been already, and many times, told in magazines and feature newspaper articles, how Surgeon Walter Reed, with his associates, Doctors Aristades Agramonte, James Carroll, also of the United States Army, and Jesse Lazear, through

diligent study and painstaking investigation worked out to a satisfactory conclusion, that a mosquito of a certain species became the carrying host of yellow fever. The theory was not a new one, and had been advanced by Dr. Carlos Finlay many years before, and had been strengthened by the discoveries of Dr. Henry R. Carter, of the U. S. Public Health Service, in his independent investigation on the "extrinsic incubation" of yellow fever by the mosquito. But this is not what is desired to be told here. What should be told is this: That although volunteers were secured to pursue the study through human experimentation, yet a sufficient number could not be gotten without a money inducement to accept the hazard. It had been found that animals, such as guinea pigs and rabbits, would not respond to the bites of supposedly infected mosquitos. Therefore, without human material with which to continue the investigation, the work of the Commission would be seriously interfered with, and delayed. It was currently reported on the Florida side of the Gulf Straits, that Official Washington had frowned upon the human experimentation plan of pursuing the work, and no money would be forthcoming. The truth of this rumor is not vouched for and it may be only a rumor. However, enlisting the sympathy of Governor-General Wood, money was given from the Cuban Treasury and the search after the scientific truth proceeded. Be it remembered and never forgotten that General Wood was primarily a Medical Man when the Spanish-American War commenced, a Medical Officer in the U. S. Army, and it was but natural that he should be interested in a work which his early life study would lead him to, and his former colleagues were engaged in, and that he should see it followed up and completed. A member of the Commission, the only one now living, writes that five thousand dollars was authorized by General Wood from the Cuban Treasury, and was justified by results which the Cuban Government received as well as humanity in general. While the "Fever Commission", of which Dr. Reed was the head, was working out problems connected with the propagation and transmission of yellow fever, Dr. Gorgas, who was Chief Surgeon on General Wood's Staff, and in charge of sanitary management of the City of Havana, was straining every effort towards making the city a clean and healthy place to live in. In this endeavor it is known that Dr. Gorgas received



the moral and financial support of General Wood. Mrs. Gorgas, in writing the life of her husband, the General, speaks of an occasion when General Wood, on leaving the city for an inspection elsewhere on the Island, told Dr. Gorgas to expend fifty thousand dollars, if necessary, in carrying out his plan of sanitation. It will be seen, therefore, that General Wood, while Military Governor of Cuba, gave tangible assistance of great value to the Medical Men of our Government in the stupendous work which they had undertaken. When Reed's fever commission had completed its work, and it had been demonstrated beyond dispute by all who were engaged in the investigation, that a mosquito of a certain species was the responsible culprit, and that propagation and transmission of yellow fever, made by a circle of infectibility, is made by the mosquito, the task of freeing the human from the curse of this disease was only commenced. To Dr. Gorgas, therefore, fell the burden of work by destroying the insects in their breeding places, which was an undertaking of no mean proportions. So effectively did he do this work not only in Cuba but on the Canal Zone of the Isthmus of Panama, that there is not a student of the High School Grades in the United States who does not now know of Dr. Gorgas and of his humanitarian work. The same principles of extermination have been applied to eradication of malarial mosquitos. A quartet of Scientists, all four Medical Men, Reed and Carter, to complete the work commenced by Finlay and Wood to make possible the scientific research by supplying necessary funds to "carry on" and Gorgas to put into practical operation, by a systematic plan, what had been proven by Reed and Carter. No mosquitos, no yellow fever, no malaria, no dengue, and perhaps many other diseases caused by bacterial or parasitic infection. The American Medical Profession has just reason to be proud of what her sons have accomplished in the recently past century. Nor should it ever be forgotten that a Medical Man of superior intelligence and scientific ability was by chance at an auspicious and psychological moment the Military Commander of the Island of Cuba.

Since 1887 Florida has experienced three epidemics of yellow fever, but the disease was circumscribed in spread and confined to a limited area, beyond which travel and commercial intercourse was not hindered. The epidemic of yel-

low fever in 1899 was imported into Key West by a child whose immunity to yellow fever was thought to have been duly proven before leaving Havana. It will be remembered that although our government had control of Havana and exercised supervision over the quarantine system of vessels and passengers leaving that port for ports in the United States, through the Public Health Service—then the U. S. Marine Hospital Service—nevertheless, through false certification of parent or family physician, this child who evidently had acquired infection of yellow fever in Havana, was permitted passage to Key West. Yellow fever then prevailed in Havana, notwithstanding the United States military authorities were exercising every precaution and adopting all known means to suppress the spread of the cases. Under the administration of the U. S. army engineers, a chlorine plant was constructed at a cost, it was said, of fifty thousand dollars, by which a current of electricity was passed through sea-water, which was then used to sprinkle the streets in an effort to destroy the supposed but invisible germ of yellow fever. And yellow fever continued to exist in Havana until Surgeon Gorgas of the medical department of the army, acting upon the developed theory of Finlay by Reed in his practical demonstration of cause and propagation, instituted a vigorous campaign against mosquitos and their breeding places. As soon as this work of Gorgas was fairly started, yellow fever cases rapidly became less and less, and finally ceased. As a "hold-over," the distance was so short between Miami and Key West, and communication so frequent, before the disease was recognized at Key West, Miami became infected also in 1899, but there was no spread, however, of yellow fever two miles from Miami and the existence of the disease was short. Neither did the fact of yellow fever having occurred in the summer have any appreciable effect on travel to Miami the following winter, and tourists came in large numbers, more so than in any previous season. In 1905 there was an epidemic of yellow fever of no mean proportions in Pensacola. The fever was brought to Pensacola from New Orleans in the early fall months by Italian excursionists who had availed themselves of a reduced excursion rate from Pensacola to New Orleans. These excursionists had been in New Orleans, in the Italian quarter of the city, for ten days. It was learned that subsequent to the discovery of con-



valescent cases in Pensacola yellow fever had existed in New Orleans for several weeks, but the knowledge of that fact had been kept concealed from the general public by the city authorities of New Orleans. It is learned that yellow fever which had been brought into New Orleans from Havana in an obscure case, found lodging in the Italian quarter of the city, soon spread among susceptible subjects, who in turn by infected mosquitos infected excursionists from Pensacola. A death of two in Pensacola under doubtful circumstances had aroused the suspicions of Dr. Warren E. Anderson, and he immediately notified by code telegram the State Health Officer, who was in Jacksonville. A patient search uncovered several convalescent cases. Had the persons living in the infected area listened to and followed the advice given by the state health authorities, it is firmly believed that the "fever" in Pensacola that year would have been conquered within ten or twelve days. But when was advice ever taken by a fear and panic-stricken people? Before the health authorities could establish a cordon around what was thought to be the infected section of the city, the citizens therein had scattered to other parts of the city, where foci of infection was established through the agency of mosquitos and within two weeks an epidemic of yellow fever was underway, which lasted nearly three months. Yellow fever had been announced at New Orleans and the prevalence of the disease in the two cities made similar progress, although owing to the difference in population, the mortality and greater spread was more in evidence in New Orleans than in Pensacola. There was this marked difference, however, in the course of the disease in both places: in New Orleans the fever spread from the city to the country beyond and to neighboring states. In Pensacola the disease was firmly restricted to an area not beyond ten miles of the city's limit in all directions. And another difference was marked; the disease was conquered and had disappeared in Pensacola before the advent of frost. The excellence of the work performed by the State Board of Health during that campaign, and the triumph of practical sanitation, with the completeness of the report made at its finish should not be overlooked by those who may be interested in the progress of health management as recited in the health history of the state and minutely in the annual report of the board for that year.

Coming to the close of the half century of health work in Florida, it should not be forgotten to mention the forward movement in sanitation, second to and matched only by the eradication of yellow fever in the city of Havana and on the Island of Cuba in the early part of the present century. The campaign for suppressing breeding of mosquitos in Florida which has been vigorously carried on by the State Board of Health for the past four years, can only be equaled in value and importance to humanity by the work which, commencing with Carlos Finlay of Havana, developed by Walter Reed of the army and finally brought to a successful consummation by William C. Gorgas, also of the army, in the conquering of yellow fever. When the State Board of Health undertook an intensive study to suppress breeding of anopheles mosquitos by drainage and screening of homes or living quarters, localities in the state which were known from statistical reports to be malaria saturated were selected in which experiments were to be made. The cooperation of the millmen and operators of other industries, vitally interested in keeping their employees well and "fit" to work, was solicited. With funds generously supplied from private sources, the scheme devised and mapped out, and what is more, carefully carried out, after six months' trial were so surprising to even the most skeptical at first of results hoped for, that plans were enlarged and a malarial area soon changed into thriving settlements of healthy working men, and cheery women and children. These trial tests gave encouragement to the officials of the State Board of Health further, to interest the public of the State as a *whole* in the project to rid Florida of a disease which was sapping the energy and life blood of its citizens, retarding immigration, and withholding financial aid in the development of the state. The sanction of the State Board of Health was given to the proposition of suppressing mosquito breeding in Florida, and George W. Simons, Jr., the sanitary engineer of the board, was entrusted with the difficult task of arousing sentiment in its favor.

"Suppress the mosquito" was a companion slogan to "swat the fly" and soon the enthusiasm of *one* man filled the minds of others. Then came an organization, "The Anti-Mosquito Association of Florida," to spread its propaganda in behalf of the great object hoped for—the suppression of mosquitos of all species, host carriers

of disease, as well as religion-destroying and comfort-forbidding variety. To George W. Simons, Jr., is due as to no other one man in the state, the inspiring enthusiasm in this work of preventing mosquito breeding, and in bringing to his assistance through faith in his teaching and by influence a cooperation of communities and individuals thereof. When the state will soberly consider what it means to have the stigma of malaria removed from Florida—for the opprobrium is hurled at the state whenever people to the north speak of health conditions—and persistently set about to remove the breeding places of the malarial mosquito, the insect which acts as a host to the malarial parasite, Florida will develop more and more rapidly in the waste places, where unhealthy conditions now prevail because of malaria existing. Money appropriated by the state for drainage of swamps and filling in of marshy spots will return fourfold in immigration and industries created thereby and thereon. At the present writing, there is pending before the Florida Legislature now in session a measure which will permit communities, counties or restricted districts, to issue bonds on approval vote of the citizens thereof, for purpose of drainage, ditching and filling marshy sections of the state, where the host mosquito of malaria breed and thrive. It would be well for the Medical Association of the state to go on record as endorsing such a measure.

An event of the epidemic of yellow fever in Miami in 1899 should be always remembered by the citizens of that city, for it stands forth prominently as an incident of generosity, modestly tendered to a stricken community. The budget of the State Board of Health had been greatly reduced during that year, by reason of a cutting in half of the millage which the statute allowed for the maintenance of the board. Under authority of the Governor this was done, which greatly lessened not only the routine activities of the board, but deprived the board from monetary assistance to the communities of Key West and Miami of absolutely necessary funds for controlling and restraining the spread of the disease during the summer and fall months of that year. This strained condition of finances came to the attention of Mr. Henry M. Flagler. The need of money to pay promptly for service rendered, which experience had shown was the only economical method of management in order to obtain the most efficient service, no doubt ap-

pealed to the business mind of Mr. Flagler. This information was probably acquired through Mr. Joseph R. Parrott, Mr. Flagler's chief aid in the development work on the East Coast, who kept in touch with conditions existing at Miami. Without consulting the State health authorities, Mr. Flagler at once telegraphed the State Health Officer to draw on him for *whatever funds* he needed and required, to render the best of service to the stricken people of Miami. The humanitarian motive which prompted this act of unlimited generosity, which followed, bears testimony to the Christian character of the man to whom Miami, and the entire East Coast of Florida, owes a deep sense of gratitude. That the financial assistance, thus given in a most modest way, was blessed, was shown by the fact that a temporary hospital was soon constructed for the care of strangers and otherwise homeless sick, of both sexes and races, in which not a death occurred. There are many now living in Miami who are personally acquainted with the incident mentioned, and other gifts of Mr. Flagler during that epidemic. The writer cannot let this opportunity pass without expressing his personal gratitude to the memory of Mr. Flagler, for an expression of confidence in him such as is not often given to almost a perfect stranger, that of placing his pocketbook in his hands with unlimited authority to use, nor should Mr. Flagler's able lieutenants, those masters of industry, Mr. J. R. Parrott and J. P. Beckwith, be overlooked in a mete of praise for their assistance in the epidemic at Miami in 1899.

In concluding this somewhat disjointed paragraphical narrative of recollections connected with the health history of the state during the past thirty or forty years, but little attempt has been made to enter into details of administration and only the prominent features of health administration has been touched upon. Many incidents connected with the work of the State Board of Health in its early days could be mentioned, some amusing and others pathetic, but a paper for the association should not be made too long and thus become tiresome to listen to. However, for those who may be further interested, the Reports of the Board from 1889 contain much of a historic nature pertaining to the state health administration, and should be consulted; especially do the Reports of the Board for 1905 give graphic accounts of yellow fever prevailing in Pensacola that year, with maps of location of



cases and names of yellow fever victims. There will be found in that volume a story by Dr. Charles W. Bartlett of Tampa descriptive of a "ferreting out" of a case of yellow fever in West Tampa in an Italian from New Orleans that summer, who had surreptitiously come to Tampa and was concealed by some of his countrymen. This account equals in vivid word painting how Dr. Bartlett perseveringly searched for the case under difficulties comparable only in Sherlock Holmes' detective descriptions. Today the State Board of Health has the confidence of the people firmly established in its capacity, ability and honest purpose in bringing forth every aid in sanitary progress and state reputation. It has now a smooth road to travel in carrying out its various methods in civic and rural health improvement. It was a different matter from 1889 to 1900, when, as has been before mentioned, each Legislature had in some of its members, determined ones, who sought to repeal the law creating the board, because, as it was said, to be an additional burden of taxation on the state as a whole, which should be borne by the seaport counties. It was charged that those sections of the state were directly benefited by a marine quarantine system, and should pay for the cost and not the state as a whole. To use a popular phrase of the street, "the sledding" was hard during that early period, the cobblestones of ignorance and an opposition aroused thereby to health measures of all kinds because of "cost" was hard to overcome and understand, and untold obstacles were thrown in the path of progressive sanitation.

It must not be assumed that the good ship "State Board of Health" has had smooth sailing over the rough waters of political seas since launching in 1889, and has not narrowly escaped being wrecked on the rocks of prejudice and opposition. During the first ten years of its existence each succeeding Legislature contained some members, principally from the interior counties, who made strenuous efforts to repeal the law by which the board was created; but the management of the epidemics of yellow fever in Key West and Miami in 1889 and again in Pensacola in 1905, when the fever was confined to the two localities that fall, leaving travel and business in the state untrammelled and uninterrupted ten miles beyond Miami, convinced the most skeptical of the necessity for a central health governing body. Since that period the Legislatures

have been friendly and generous in their cooperative assistance.

An important feature of the early days of State Board of Health Management, and which should have been recalled and mentioned before, was the forming of the "Legal Advisory" Department or Division. Immediately after organizing, with Dr. R. P. Daniel as President, and Messrs. W. B. Henderson and W. K. Hyer as Members, a State Health Officer was appointed, and following which, the next important step taken was the selection of a Legal Advisor to the Board. This determination was very wisely taken, because there were no precedents of similar Boards to be followed, and in formulating rules and regulations to govern and control quarantine procedures, whether maritime or domestic, many and varied phases of administration had to be considered which should be agreeable and safely adaptable to the different sections of the State.

While the Special Session of the Legislature of February, 1889, in the enactment of the State Board of Health law, had been delegated ample authority and powers to devise and decree imperative necessary methods for protecting the public health, yet the Statutes of the State had to be consulted and examined that in drafting further rules and regulations no conflict with existing laws, which the Act had not abrogated, should be had. Accordingly the Hon. Rydon M. Call, an Attorney of Jacksonville of prominence and a personal friend of the President of the Board, was selected as legal advisor to the State Board of Health. Later on Mr. Call associated with him Mr. Charles S. Adams, who had been Secretary of the Jacksonville Auxiliary Association during the epidemic of yellow fever at Jacksonville in 1888. When Mr. Call was appointed Judge of the Fourth Judicial Circuit of the State, the vacancy was filled by the selection of Mr. E. J. L'Engle, also an Attorney, and a brother-in-law of Mr. Adams. These gentlemen served the Board very agreeably, satisfactorily and efficiently for a number of years. The writer wishes to express his grateful thanks to all three of them in the aid and assistance given him, when State Health Officer, by advice and counsel, as he had frequently to consult them and seek their help in steering clear of many shoals and reefs of disputed authority, which were constantly being raised by the public at first, when he was merely endeavoring to put in operation successful measures calculated to



protect the health of the State. Mr. Adams withdrew to more lucrative fields of law practice from the firm of Adams and L'Engle several years before his death, but Mr. L'Engle continued to remain as Legal Advisor to the Board, only with the distinct understanding that there was to be no remuneration attached to his service. Mr. L'Engle was the close friend and advisor of the writer of this narrative, in all matters likely to affect the welfare of the Board of Health, until he resigned from the State Board of Health in 1917, to enter the World War in his professional capacity on the active list of the Army.

Many pleasant conferences are now recalled when views were exchanged and policies, designed for the betterment of the health of the State, were freely and thoroughly discussed before being adopted. For at these conferences not only was the legal advisory aspect of any recommendation considered, but likewise the practical and tactful features of the proposition, as due consideration was always given to conciliatory measures rather to a punitive enforcement. The wisdom of the action taken by the members of the State Board of Health at the very commencement of their organization was amply justified, when it is told that in the twenty-eight years of service of the writer, not a single case was brought before the Courts of the State for adjudication, EXCEPT one, which will be presently recited. This case, which was an amusing one, is recalled when speaking of the "legal advisory" or otherwise it would not perhaps have been remembered.

Many of the readers of this article will remember—for it was not so long ago—that during the Spanish-American War period, Volunteer troops intended for the Cuban campaign, were camped in large numbers at several places in Florida—Jacksonville, Tampa and Miami—awaiting transfer to Cuba. Included in the camp sites were the Quartermaster's Equipage of horses, mules and other necessary camp supplies, likewise awaiting transportation. The horses and mules were always corralled on the outskirts of the city or town where camps were maintained.

At Jacksonville, a large corral of horses was being held, and, unfortunately, glanders appeared among the herd. As soon as discovered by the Civil Authorities, the Officer in charge, who was a Volunteer Major of the Quartermaster's Department, was advised that a complete segregation of the animals should be made, that the

native stock might not become infected. But supposedly not wishing to be hampered in administration, the Major Quartermaster decided—possibly under authority of higher up—to sell the glandered horses at public sale, and he advertised his intention by posters and hand-bills. As soon as this information came to the knowledge of the State Health Authorities, the Sheriff of Duval County was directed to inform the Officer in charge of these horses, that a sale would not be permitted, and further, to arrest any one attempting to make such a sale. This brought the Major to the office of the State Board of Health, with a violent protest against an interference, as he said, in the United States Government affairs. A few minutes' conversation convinced the Major that the State Health Authorities would not yield in the stand taken and he left still threatening to carry out his purpose. At the time the Sheriff notified the Major Quartermaster, of the instructions given him, the legal advisor of the Board applied to the Judge of the Fourth Judicial Circuit of the State for an injunction restraining the Major Quartermaster from carrying out his proposed intention of sale. The Judge issued the necessary papers and the injunction was made returnable to be argued in Chambers before him on a certain date. It suffices to say that when the argument was made, the injunction was made permanent. Soon afterwards the horses were shipped to Cuba, but whether or not the native stock in that island was infected was never known.

The appearance of the Major Quartermaster as he entered the office of the State Health Officer to make his protest against the interference, will never be forgotten. "Bombastes Furioso" could never have been so completely satisfied with his "get up" nor his importance than was the little Quartermaster Major. Garbed in a new uniform which fitted perfectly, and was fully buttoned, with gold leaf insignia of rank on his shoulder straps, with cape thrown over one shoulder—for the air was crisp—in true Napoleonic fashion, and cap sitting squarely on his head, a Major General of the Regular Line could not have been more imposing in appearance nor visaged a more awe-striking countenance.

The unpleasant features of this incident were dispelled when a letter was received a day or two afterwards from the Chief Quartermaster of the Department apologizing for the "faux pas."

which his subordinate had made, and greatly regretting its occurrence. Colonel Geo. E. Pond, U. S. Army, the Chief Quartermaster of the Department, happened to have been the roommate and messmate of the State Health Officer when they both served in the army at Fort Ringgold, Texas, a frontier post, on the Rio Grande River. A firm friendship sprung up then between them and has continued throughout the past years. As his name no longer appears in the Army Register, either on the active or retired list, it is presumed that he, too, with many another of the writer's army friends, has joined the Silent Majority in the Great Beyond.

And now dropping the use of the third person—in which this article has hitherto been written—I think that these "remembrances", unconnected in sequence and merely "memory wanderings", should be brought to a close, lest I be accused of having reached the garrulous old age of which Shakespeare speaks—not knowing when to stop. I am, however, conscious that quite a few interesting topics have been left out which should not have been overlooked. The task was undertaken more as a test of memory and was not intended to be lengthened out as it has been. There are some names which should have been mentioned and this "Looking Backward" would not be satisfactory or finished were mention not made of Dr. D. M. Echemendia, who did such efficient work of disinfection of residences after the epidemic of yellow fever in Jacksonville in 1888, and was for many years quarantine officer at the Tampa Bay Quarantine at the mouth of Tampa Bay, Florida. There are yet many travelers living and passing to Havana by the way of Tampa each year who will remember the genial Cuban Doctor who had a pleasant word for everybody coming under his surveillance, and who made his inspection with a tactfulness that never disturbed the disposition of even the most captious of such official requirements.

Nor will the captains of the thousands of the merchant marine of the world—those who roam the seas—who may be now living, likely to forget the name of Dr. Robert White, the Quarantine Officer of the port of Pensacola. Dr. White was a Martinet in quarantine procedures, but most

careful and thorough and exacting in his work, that the letter as well as the spirit of the regulations should be complied with. He and his wife lived an isolated life during the summer season—at the Quarantine Station on Santa Rosa Island—the season of active quarantine management—but was permitted to live in the city of Pensacola during the winter months. Vessels during the winter were boarded when incoming from foreign ports, in the harbor, off the docks.

Memory would totally fail me did I forget to mention the name of Dr. J. L. Horsey, of Fernandina, who was up to the time of his death a few years ago, Quarantine Officer of the port of Fernandina. A gentleman of "the old school"—although yet young at the time of his death—his kindly and courteous personality won for him many friends in all walks of life, which gave confidence to his judgment in matters of preventive medicine. Neither should the name of Dr. C. B. Sweeting, of Key West, the Quarantine Officer of that port, be omitted from the quartet of efficient sanitary guardians of the principal ports of the State.

They served the State with untiring energy and devotion—and with but small compensation—in excluding shipping coming from foreign ports which without careful inspection might threaten the health of the people.

These faithful servants of the State have "passed on" to another sphere of useful activity in the Spirit World, but the memory of their active interest in the health welfare of the State in their several functioning, while alive, will be pleasantly remembered by those who daily associated with them for thirty or forty years.

I wish to express a deep sense of gratitude before closing to Senator D. U. Fletcher and Senator Park Trammel, and like to Mr. W. L. Hill, the efficient and courteous Secretary of Senator Fletcher, for their valuable aid in confirming from official records of the Government many of the statements which are made in these pages merely from memory.

I trust that my "scraps of memory" have not been tiresome to my readers and on the contrary pleasure may have been found.

[END]

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## AEROPLANE TREATMENT OF DEAFNESS

Oto-laryngologists are frequently consulted with reference to the value of dropping in a plane to cure deafness. The very inaccuracy of reports in the public press about people suddenly regaining hearing is naturally hopeful, even though amusing.

One suffering with hysterical deafness might be greatly improved in a trip through the clouds; in fact, any other form of hysteria would as likely be benefited. But the authenticated cases of deafness are those that are of interest to the

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medical profession, and they are the ones that should be investigated and reported.

In a brief analysis of deafness we describe lesions in the external, middle, and internal ear. A ride through the clouds would hardly dislodge an inoffensive mass of inspissated cerumen or revive a dead labyrinth, but our imagination could carry us far enough to perceive a definite effect on an ossicular ankylosis, whether brought about by altitude or vibrations.

So it behooves us to thoroughly investigate the cases that are occasionally reported and analyze the lesions, not for the purpose of adding another chapter to otologic therapeutics but in fairness to the practice of progressive medicine.

### BALDNESS

The loss of hirsute adornment in the modern adult male is an increasingly evident state. There are but few of us who are spared. The average



layman, and many medical men, resort to the various hair tonics and advertised hair restoratives in an effort to avoid dandruff and its resultant hair loss. Medical science has neglected to a great extent the study of these conditions, and there are but few medical men who seriously consider its treatment. It is for this reason that charlatanism and patent remedies are resorted to, for the layman thinks his physician will not consider seriously the treatment of the scalp pathology. The following is from the health news service of the New York Department of Health and brings this important matter in a very clear manner to the layman:

"Baldness was the subject of a talk by Dr. Louis B. Mount of Albany, broadcast Friday night from station W. G. Y. This was one of the health talks arranged for that station each week by the State Department of Health.

"Dr. Mount deprecates the advice of the barber or hair dresser and states that so-called beauty specialists are wholly ignorant of the most elementary principles of medicine. He gives some sane and simple advice about the care of the scalp and hair in order to prevent baldness, and urges those, whose crowns are thinning, to seek the advice of their family physicians.

"'Loss of hair or alopecia, as it is called technically', said Dr. Mount, 'is a cosmetic defect due to many causes. Some of these are beyond our control, but many of them we can regulate.

"'The hair being a part and parcel of the body, it demands just as much care and attention as other parts. This care should begin in childhood. It is not necessary or advisable to wash too frequently a child's scalp when it is in a normal condition. Cleanliness is the only purpose of the shampoo. The normal scalp of the child is usually fairly free of fat, so it is well to apply a grease such as olive oil after washing to prevent abnormal dryness. In children the scalp should be watched for the appearance of scaliness, and when this occurs suitable treatment should be instituted.

"'Harsh and irritating substances should be kept away from the scalp. The purpose of washing the hair and scalp is to remove dirt, and it should be done with the least amount of chemical irritation. This is best accomplished by using a soap in which the excess of alkali has been neutralized—a so-called neutral or super-fatted soap. Fancy soaps are fancy in price only; they pos-

sess no virtues which make them desirable for the purpose under discussion.

"'One of the contributing causes to loss of hair is unquestionably the wearing of tight, constricting head coverings. The so-called hatless craze is a step in the right direction, for it not only does away with any constriction of the scalp, but exposure to the rays of the sun has a marked stimulating effect on the regrowth of hair. However, consideration must be given to climatic variations in certain sections of the country and undue exposure avoided.

"'It has been estimated that, normally, a person loses about forty hairs each day. The important point to consider is not so much the number of hairs lost as the quality. It has been shown that if, in the accumulated combings of three consecutive days, the number of hairs under six inches in length form one-third of the total number lost, there is a disease of the scalp which requires medical attention. Of course, this only applies to the female sex, not including those who have boyish bobs. In the case of the latter and of males, the distinction is made by differentiating those hairs which show traces of the barber's scissors from those which have a pointed end. The number of these must be only one-fifth or one-fourth of the total of hairs, four inches in length.

"'When thinning of the hair becomes apparent, most people accept the advice of the ever-ready barber or hair dresser, who talk glibly about the necessity of singeing the hair in order to seal up the pores after cutting. This is a perfectly ridiculous procedure and accomplishes absolutely nothing. One after another the whole gamut of so-called hair tonics or washes are tried, but all in vain. Many fall into the clutches of the non-medical, self-styled beauty or hair specialists, people wholly ignorant of the most elementary principles of medicine. The hair seeker is told that his hairs are coming out with their roots. Nothing could be more untrue than such a statement. The lowest part of the shaft has a small swelling, the bulb, always pointed out as the root, but which really has no connection whatsoever with the growth of hair.

"'So, if your hair is disappearing, why not be sensible? Consult with your family physician. If he cannot help you or does not feel that he is qualified to advise you, he, as your friend, will surely direct you to some one else who will interest himself in your condition.'"

## STATE NEWS ITEMS

*This department is supervised by Dr. Ralph N. Greene, Jacksonville. Members of the State Association are requested to forward to Dr. Greene or the Editor such news items as they may think of interest to the readers of THE JOURNAL.*

Dr. J. M. Hoffman spent the Christmas holidays in New Orleans.

Dr. C. J. Heinberg, of Pensacola, spent a part of his Christmas vacation freezing in Chicago and telling them about Florida's wonderful climate.

Dr. J. S. Truberville, of Century, attended the meeting of the Southern Railway Surgeons and Southern Medical Association in Dallas.

Dr. M. A. Lischkoff, of Pensacola, read a paper on "The Prevalence of Sinus Infection" at the Dallas meeting of the Southern Medical.

A joint meeting of the Pensacola Hospital staff and the Escambia Medical Society, held Tuesday night in the Pensacola Hospital, elected the following officers for the ensuing year: Dr. J. H. Fellows, President; Dr. J. H. Hoffman, Secretary; Dr. H. L. Simpson and Dr. Clarence Hutchinson, Executive Committee. Officers for the Escambia Medical Association chosen, were: Dr. Herbert Bryans, President; Dr. Herbert Snyder, Secretary-Treasurer; Dr. V. R. Nobles, Vice-President; Drs. M. E. Quina and W. C. Payne, Censors.

Dr. W. P. McKee, of Eustis, was chosen president of the Lake County Medical Society at their annual meeting Thursday. Dr. H. K. Harrison, of Leesburg, was made vice-president, while Dr. Sanford C. Colley, of Taveres, was made secretary-treasurer.

Dr. John S. McEwan, President of the State Medical Association, spoke on the value of organization to the county and to the state as a unit in the general medical profession. He advised the members of the society not to hesitate at taking action which would improve the organization as it now exists.

Twenty members were present and decided to hold monthly meetings at which discussions of matters pertaining to the profession would be held.

At a recent meeting of the Alachua County Medical Society plans were discussed pertaining to the coming annual meeting of the Florida Medical Association in Gainesville, next May.

Fourteen members were present and all were enthusiastic in their desire to make the fifty-third annual meeting a great success.

Dr. Dandy, of Baltimore, was a recent visitor to Jacksonville.

Dr. Shaler Richardson, of Jacksonville, read a paper on Squint, before the Alachua County Medical Society at their last monthly meeting in Gainesville.

## STATE BOARD OF HEALTH NEWS

Inasmuch as there have been quite a number of cases of smallpox reported from various parts of the State, it is thought wise to call the attention of the profession to resolutions adopted by the State Board of Health at a meeting, June 16, 1921, and which were published at that time:

"WHEREAS, Vaccination and revaccination offer the only preventive for smallpox, and

WHEREAS, the majority of smallpox cases occurring in the State are not seen or diagnosed by a physician, and

WHEREAS, the quarantine or isolation of the relatively few known cases of the disease gives the public a false sense of security, now therefore

BE IT RESOLVED, that the State Board of Health of Florida hold every individual or citizen responsible for the prevention of smallpox in himself or immediate family and that the public be advised that such prevention can be obtained on application to the State Board of Health for smallpox vaccine.

BE IT FURTHER RESOLVED, that the State Board of Health of Florida furnish free vaccine to any citizen of the State and wherever an epidemic of smallpox is threatened it make every effort to detail a District Health Officer to the infected community to give free vaccination service to the public.

BE IT FURTHER RESOLVED, that the State Board of Health of Florida will not quarantine smallpox, nor will it be responsible for the treatment, maintenance or sustenance of any case of smallpox occurring within the limits of the State."

There have been several outbreaks of a virulent type of smallpox within the past few years at widely separated points: Denver, Kansas City, Chicago, Minneapolis, Detroit, Windsor, Ontario. The mortality ranging from 10-47% of the cases.



In the Detroit outbreak in 1924, of 1610 cases not one of them had been vaccinated within five years, and 85.36% had never been vaccinated; while of the 163 deaths in this outbreak not one had been vaccinated within ten years, and 88.48% had never been vaccinated.

Vaccination is a very simple form of life insurance and no one can tell when an outbreak of the virulent type may occur unless we all do our best to stimulate vaccination.

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#### REPORT OF EXECUTIVE COMMITTEE ON FINANCIAL STATUS OF THE FLORIDA MEDICAL ASSOCIATION

Jacksonville, Fla., Dec. 18, 1925.

Doctor J. S. McEwan,

President, Fla. State Medical Association,  
Orlando, Fla.

Dear Doctor McEwan:

A special committee appointed by you in July to investigate the books of the Florida Medical Association as submitted to the present secretary-editor, Doctor Shaler Richardson, by the former secretary-editor, Doctor Graham Henson, presented to your Executive Committee the following report:

October 9th, 1925.

Doctor John S. McEwan,  
President, Florida Medical Association,  
Orlando, Florida.

Dear Doctor McEwan:

The undersigned committee appointed by yourself to investigate the books of the Florida Medical Association as submitted to the committee by the former Secretary-Treasurer-Editor, Doctor Graham E. Henson, and audited by public accountants Messrs. Mucklow and Ford, show no discrepancy of entry.

The former Secretary-Treasurer-Editor, Doctor Graham E. Henson, has obligated the Florida Medical Association to the amount of approximately three thousand dollars (\$3,000.00) with the Florida Record Company of St. Augustine, the Record Company being the publishers of the Journal of the Florida Medical Association. The obligation is in the form of a note signed, Florida Medical Association, by Graham E. Henson, Secretary-Treasurer-Editor, and the note referred to was signed during the month of November, 1924.

It appears from the Florida Record Company's

statement that Dr. Henson obligated the Florida Medical Association by a similarly signed note as above mentioned, he having given the Florida Record Company a note in the amount of five hundred dollars (\$500.00) in 1916. From time to time after 1916 the note signed by Doctor Henson, as Secretary-Treasurer-Editor for the Florida Medical Association, has been increased in amount. For a more detailed statement of the Florida Record Company's account you are referred to Doctor Shaler A. Richardson, the present Secretary-Editor.

So far as your committee is advised, no officer of the Florida Medical Association, except the former Secretary-Treasurer-Editor, Doctor Graham E. Henson, since 1916, has had any knowledge of the obligations assumed by Doctor Henson.

The former Secretary-Treasurer-Editor reported to the Florida Medical Association at its annual meeting in May, 1924, at Orlando, Florida, and at St. Petersburg, Florida, May, 1925, as appears in the proceedings of the said meetings, that the association had no outstanding obligations. At the meeting in St. Petersburg in May, 1925, the former Secretary-Treasurer-Editor was congratulated, by a rising vote of the Association, on his commendable report, which, according to the information of your committee, is said to have shown a balance of one thousand dollars (\$1,000.00) in the treasury and no indebtedness.

The present Secretary-Treasurer-Editor, Doctor Shaler A. Richardson, received from the former Secretary-Treasurer-Editor, Doctor Graham E. Henson, the sum of \$307.17 when Doctor Richardson assumed his duties as successor to Doctor Henson. It appears that the books, as received by Doctor Richardson from Doctor Henson, indicate two payments to the Florida Record Company of St. Augustine in the sum of \$775.00. Said payments being made between the annual meeting at St. Petersburg, May 19th and 20th, 1925, and June, 1925. To be more explicit, it appears from the records that the payments made by Doctor Henson to the Florida Record Company at St. Augustine, were made after the St. Petersburg meeting and before turning the books over to Doctor Richardson.

When Doctor Henson filed his report at the St. Petersburg meeting in May, 1925, showing the sum of One Thousand Dollars (\$1,000.00) in the treasury and no indebtedness, he omitted to mention the note obligating the Florida Medical



Association to the Florida Record Company in the sum of three thousand dollars (\$3,000.00).

It is the opinion of your committee that the above statements set forth the main facts.

We trust that the information herein contained will meet with your requirements and enable you to present the matter more clearly to your executive committee.

Respectfully,

R. H. McGINNIS.

H. M. TAYLOR,

RALPH N. GREENE.

A copy of this report was submitted to Doctor Henson and he was invited to be present at the meeting of the executive committee whenever it was decided to convene for the purpose of considering the report.

Doctor Henson addressed to you the following communication relating to the report of the special committee:

November second,  
Nineteen twenty-five.

Doctor J. S. McEwan,  
Orlando, Florida.

My dear Doctor McEwan:

Your letter with enclosure did not reach me until today noon. As you did not state the place or date of the meeting of the Executive Committee meeting, to be held this week, I have sent to Doctor Love a copy of this communication.

The report of the committee you sent me seems to record the transactions I had with the Record Company. There are just one or two points you would not understand without my explanation. The payment made to the Record Company between the election of Doctor Richardson and my turning the books over to him were due to the fact that at his request I carried on until the close of that month. Two hundred and seventy-five dollars was paid, as by agreement they were to be paid, for the last issue published before preparation for the succeeding issue. The other five hundred dollars had been promised them as soon as the funds became available. I would also impress your committee that the indebtedness was one that was in reality incurred when we were having a hard time to keep the Journal going, that is, during 1917 and 1918. In addition to notes held by the Record Company during that

period, we had at that time also an open account. For the last several years the Journal was actually paying for itself, the indebtedness being dead wood, so to speak. Doctor Warren, who took care of the work for me while I was away during the World War, is familiar with conditions as they existed during that part of the Journal's history. To summarize: For several years we had a large open account with the Record Company in addition to a note that was carried in the St. Augustine bank. As this was paid up, another note would be given them for the open account, placed by them in the bank and the matter worked out as before. About a year ago from this date, or possibly a little earlier, the Record Company underwent a reorganization and I had a conference with Mr. Scott Loftin, which resulted in my placing the entire indebtedness in the form of a note, with the understanding that no further open account would be run and the note retired as it could be. This arrangement had been working out for several months when I turned the affairs over to Doctor Richardson. My annual reports covered only cash transactions and you will readily understand that we at all times had both bills payable and bills receivable. A list of bills receivable was turned over to Doctor Richardson, together with an estimate of unpaid state dues from delinquent members for the current year. I trust this may clarify any misunderstanding relative to the transaction that may exist. If your committee is meeting in Jacksonville and you wish any further information, please call on me. If they are meeting outside of Jacksonville, I could not at this time very well get away. However, I think I have put everything clearly before you in this letter, and do not know of anything I could add.

With kindest regards,

Very sincerely,

GRAHAM E. HENSON.

A special call meeting of your executive committee assembled in Orlando, Fla., November 29th, to consider any matters relating to the welfare of the Association. Present at this meeting were Drs. G. H. Edwards and J. D. Love of the executive committee, President J. S. McEwan and Secretary-Treasurer-Editor Shaler Richardson. The third member of the executive commit-

tee, Doctor Joseph Halton, was absent. Doctor Graham Henson was unable to accept the invitation of the committee to be present.

It was disclosed at this meeting that when the books and accounts of the Association and Journal were turned over to the present Secretary-Editor, the liabilities in bills payable amounted to approximately \$4,386.86, this being the amount due the Record Printing Company and covered, for the most part, by a note given by the previous Secretary-Editor. Bills receivable, which consisted of unpaid membership dues and advertising bills, amounted approximately to \$1,002.00. There was cash on hand, \$307.17. Further liabilities consisted in unfulfilled advertising contracts resulting from three unpublished issues of the Journal. It was decided to be to the best interests of the Association that no effort be made to publish these three issues, so long in arrear, but to either refund to advertisers their claims on the Journal or to carry the advertising for three months of the current fiscal year. Your newly elected Secretary-Editor was confronted with the discouraging task of attempting to publish monthly editions of the Journal with the very meager assets just detailed. This was rendered more disheartening through the recently increased cost of printing a somewhat enlarged Journal, which increase amounts to approximately twenty per cent. With indefatigable determination, our Secretary-Editor has been able to meet the new indebtedness and to continue the publication of the Journal, up to the November issue, without incurring new financial obligations; though to further this accomplishment he has so far not drawn the salary due him for his services.

In order to continue the publication of the Journal throughout the fiscal year, the executive committee, with the approval of the major officers of the Association, have, through the issuance of a note, secured from the Florida National Bank of Jacksonville, a credit of \$2,500.00, which may be drawn upon in units of \$500.00 as the needs of the Journal demand. The note given the bank is an obligation on the part of the Association and has the personal endorsement of the major officers and the members of the executive committee. Only such part of this credit will be used as will permit the continued publication of the Journal and to defray any debts of necessity incurred.

At the instigation and expressed wish of the Secretary-Editor, Doctor Shaler Richardson, and with the approval of the president of the association, the executive committee has deemed it to the business interests of the association to employ a business manager for the Journal, to function for the remaining months of the fiscal year. It is thought that through his efforts additional members might be added to the roll of the association and new advertising matter secured for the Journal. The execution of this policy will entail but little additional expense, since the salary demanded by the contemplated business manager is merely nominal, and a large portion of it is to be secured through the generous offer of our Secretary-Editor, who donates his monthly salary to this purpose. It is believed by this committee that a competent manager will prove an asset rather than a liability to the association; and that he will demonstrate this before the expiration of the current fiscal year.

You will realize from this report the precarious financial footing of the association and that hope for relief is based largely on increased membership and an increase in dues such as will be determined upon at the next meeting in Gainesville. The indebtedness to the Record Printing Company must be allowed to stand till provisions are made for its discharge.

Respectfully submitted,

JAS. D. LOVE,  
Chairman, Executive Com.,  
G. H. EDWARDS,  
JOSEPH HALTON.

To the Members of the State Medical Association:

The above report of the Executive Committee fully informs the members of the Association of our actual financial status. In undertaking the revival of the Journal, which for several months previous to the St. Petersburg meeting had not been published, I did so after numerous deliberations with our President and the Executive Committee, who were very reluctant to see the Association publication discontinued. They have generously agreed to personally finance our work. The last financial report of the Secretary of the Association showed assets of over one thousand dollars, but did so only by omitting an obligation to the Record Company of something over three thousand dollars together with a number of current expenses. A portion of the obli-

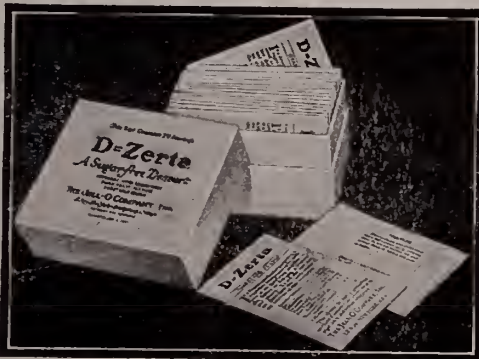
gation to the Record Company had existed since 1916. Owing to the failure of the March, April and May issues of the Journal to appear, our advertisers were ready to cancel their contracts and it was only because of the leniency and through the efforts of the Cooperative Advertising Bureau, a subsidiary of the American Medical Association, that we were able to continue a part of them. Of course, it was necessary to forfeit the revenue that might have been obtained from them during the above specified months.

After much consideration on the part of the officers of the association, and at my suggestion,

Dr. Stewart G. Thompson, of the State Board of Health, has been appointed business manager of the Journal and the State Association. He assumed his new duties, on a part-time basis, January first. Dr. Thompson's efforts will be directed toward building up the membership of the state association and putting the Journal on a firm financial basis. A whole-hearted cooperation with him in his undertaking is requested.

SHALER RICHARDSON,  
Secretary-Treasurer,  
Florida Medical Association.

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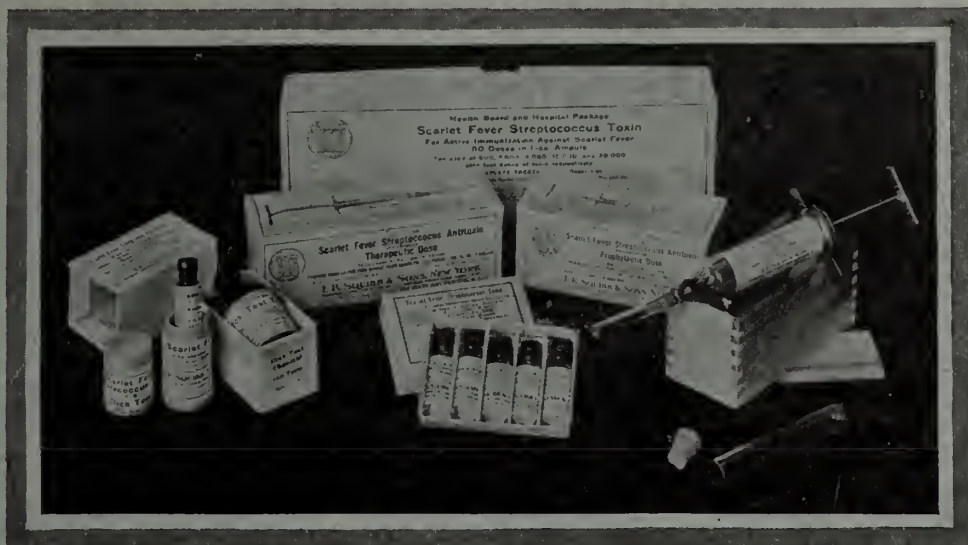
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# THE JOURNAL

— OF THE —

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XII

Jacksonville, Florida, February, 1926

Number 8

## RESPONSE TO A TOAST TO THE "EMINENT PHYSICIAN"\*

JOHN S. HELMS, M.D.,

Tampa.

This, our annual banquet, is always a delightful occasion to me. It becomes more so as the mile-posts, marking the years, go swiftly by. It is always an occasion of goodfellowship. Whatever our differences may be in the interim, we are always of one accord at this function, a recommendation for its perpetuation, if there be no other.

This occasion always inclines me to reminiscence and my retrospect harks me back to more than a quarter of a century of varied experiences. Time has wrought many changes during this twenty-five years. As I look about me, I see only a few remaining of those I found here. One by one they have been called home to their reward. Newer and younger faces are to be seen in their stead. Their vacant chairs now seat newer men in our councils. Our ranks have been refilled with younger soldiers of health, fighting disease and death.

The science of medicine has made wonderful progress during this period. The doctor of today is marvelously more skillful and scientific than the doctor of the yesterday. But the ideals that ruled and actuated the physicians of centuries ago are as true and applicable today as then.

Let us pause to take stock. Let us not be swept away with materialism. Let us remember the "eminent physician" recognizes that science has a soul. Let us not forget, in our chemico-biological enthusiasm, the spiritual side of human life. The spiritual and the psychological have much to do with the physiological. As we treat the diseased body, let us uplift the soul.

We are in the midst of the greatest sociological upheaval the world has ever seen. Let us not fail in our duty to do our part to guide the current toward the goal of human betterment.

Sociological problems should be studied and better understood by the physician to the end that the more than one hundred and fifty thousand physicians of this great country shall wield that beneficent influence over its more than one hundred and ten millions of people that is their privilege and duty.

Our country needs our loyalty and support. Let us know its constitution and its laws and let us obey them, that our liberty, bought by the blood of our fathers, and our government founded upon their ideals, may be as enduring as time. Let not the soul of science perish. Let us be truly "physicians of eminence".

## COMPARISON OF THE KOLMER QUANTITATIVE TEST WITH THE ROUTINE WASSERMANN

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We have been using the new Kolmer quantitative test for syphilis at the Bayside Hospital Laboratory since August, 1924, and have completed a series of 1328 tests to date.

One advantage of the Kolmer test is that it supplies the urgent need of a "standard Wassermann test" or uniform complement fixation test for syphilis. The chief points of difference between the Kolmer test and the old routine Wassermann are: first, the use of the new Kolmer antigen; second, primary incubation at 6° to 8° centigrade; third, the removal of natural anti-sheep hemolysin; and fourth, the employment of five varying amounts of patients' serum as follows: 0.1 ml. in the first tube, 0.05 in the second, 0.025 in the third, 0.005 in the fourth, 0.0025 in the fifth and 0.1 in the sixth tube, which serves as a control. The result of the Kolmer test is recorded according to the intensity of the reaction in each of the five antigen tubes, thus providing a true quantitative reaction which is so necessary in following the progress of a case of syphilis under treatment.

\*Delivered on the occasion of the annual banquet of the Hillsborough County Medical Society at Tampa, January 5, 1926.



For example:  
44443—Very strongly positive.  
44321—Strongly positive.  
32000—Moderately positive.  
21000—Weakly positive.  
00000—Negative.

For a time we checked out Kolmer tests with the routine Wassermann running the two tests side by side with the same sera. Table I shows the comparison of the two tests based on 269 cases.

Table I—Comparison of Kolmer with Wassermann:

Total number of cases .....	269
Negative agreement .....	217 (80.6%)
Positive agreement .....	36 (13.3%)
Kolmer positive, Wass. negative .....	15 ( 5.5%)
Wassermann positive, Kolmer negative ..	1

The sixteen cases which did not agree are analyzed as shown by Table II.

Table II—Analysis of 16 cases in which there was disagreement between Kolmer and Wassermann:

Case No.	Kolmer	Wassermann	Clinical Diagnosis
5	33300	Negative	Syphilis
11	33200	Negative	Syphilis (wife & child both positive Wassermann)
23	33310	Negative	Congenital syphilis
29	33310	Negative	Mother of Case No. 23
41	44310	Negative	Positive history
49	11000	Negative	Treated case
57	44410	Negative	Syphilis
66	32100	Negative	Treated case
74	23200	Negative	Treated case
90	44300	Negative	Positive history
114	00000	Weak Positive	Treated case
140	02100	Negative	Positive history
162	44410	Negative	Treated case
201	24420	Negative	Neuro-syphilis
244	44320	Negative	Positive history
254	22100	Negative	Positive history

In a further series of 184 cases our positive results were checked by another laboratory employing the Wassermann test. Of the 184 cases, 37 were positive by the Kolmer method. Of these 37 positive Kolmers the Wassermann was negative, doubtful, or anticomplementary in 26 and positive in only 12. An analysis of these 26 negative, doubtful or anticomplementary cases is shown in Table III.

Table III—Analysis of 26 cases which were positive by Kolmer and negative by Wassermann:

1—Treated case	9—Treated case
2—Active syphilis	10—Treated case
3—Treated case	11—Treated case
4—Treated case	12—Positive history
5—Positive history	13—Treated case
6—Syphilis	14—Positive history
7—Positive history	15—Treated case
8—Treated case	16—Positive history

17—Treated case	22—Syphilis*
18—Treated case	23—Treated case
19—Treated case	24—Neuro-syphilis
20—Treated case	25—Neuro-syphilis
21—Syphilis	26—Treated case

\*Case No. 22 presented a local lesion of eleven days' duration. A dark field examination demonstrated the treponema pallidum. The Kolmer was very strongly positive, 44310.

The value of the Kolmer test as a serological guide to treatment is shown in Table IV, in which a case of syphilis is followed over a period of eight months.

Table IV—Progress of Case of Syphilis Under Treatment:

Date	Kolmer	Wassermann*	Wassermann*	Symptoms
1925		(3+)		
Feb. 7	44432	Weak Positive	Negative	None
Mar. 7	44310	Negative	Negative	None
July 4	43100	Negative	Negative	None
Sept. 25	Not done	Negative	Negative	None
Oct. 3	32100	Negative	Negative	None

\*Wassermann tests done by two different laboratories.

This table not only shows the superiority of the Kolmer quantitative test in the diagnosis of latent syphilis, but also the superiority of the Kolmer quantitative test over the Kolmer qualitative test. With the latter test, which is conducted with one amount of patients' serum only (0.1 ml.), this case would have remained 4-plus, and apparently unimproved, until October, eight months after the beginning of treatment; but by observing the reaction in tubes four and five a marked improvement is noted within thirty days.

As shown in Table II, some cases of syphilis (Nos. 74, 140 and 201) show a weaker reaction in the first tube than in the second. In explanation of this phenomenon, I will quote directly from Dr. Kolmer: "With about 1/2% of sera the first dose of 0.1 ml. may yield a weaker reaction than the smaller amounts, as 0.05 and 0.025 ml.; indeed, with weakly positive sera, the 0.1 ml. amount may yield a falsely negative reaction, whereas true positive reactions occur with the 0.05 ml. amount. As previously stated, Detweiler has noticed this phenomenon in his quantitative tests and believes that it is due to the influence of natural antisheep hemolysin, but I have observed the reaction with hemolysin free sera and have never seen it with spinal fluids containing some hemolysin. In my opinion it is due to interference of complement fixation by some other serum constituent. Whatever may be the true explanation, the fact remains that it occurs, and constitutes the main reason for using varying

amounts of patients' serum in conducting the syphilis complement fixation test."

Dr. Kolmer's opinion is no doubt correct since we still observe this atypical reaction occasionally, altho we have for the past six months been removing the natural antisheep hemolysin from all sera preliminary to the test.

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### PERIODONTIA\*

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Periodontia may be defined as that branch of dental practice which has for its purpose the care and preservation in health of the supporting tissues of the teeth. It naturally follows that if this definition is correct, periodontia is the cornerstone of dentistry. Remove it and the whole structure of dentistry fails, for unless there is preservation of these tissues, all dental operations in their very nature are temporary, just as the care bestowed on the structure of a building is temporary if the foundation of the building be neglected.

Because these things are true, it should be the first concern of dentistry to prevent or recognize early the manifestations of disease in these tissues to the end that the teeth be preserved in health. It is evident therefore that periodontia is logically not a specialty of dentistry, but a part of dentistry that should be clearly understood by the general practitioner. We have no line clearly separating it as we do in other branches of dentistry. Moreover, another consideration is, that we are face to face with the fact that there is an universal need of more periodontia, and this immediately obligates the general practitioner to qualify himself that he may not only treat the case in hand, but that he may render service to the coming generations through preventive channels.

As to the mouth that has suffered no loss of tooth structure and possesses all normalities, we are under a great responsibility to this patient. Prevention should be our watchword, and these are the cases where we should spend enough time to thoroughly instruct the patient in the use of good old friend toothbrush. I am thoroughly convinced that a normal mouth of a healthy individual will remain healthy so long as that individual produces necessary stimulation to the soft tissues and the teeth are kept clean.

I am going to define etiology as far as understood, and treatment for the most common types of periodontal diseases. The first three types mentioned below have very little if any effect on general health, therefore, they will only be entered into briefly. The fourth type is the one of greatest concern to the physician, due to the fact that pus is always present, therefore we will go into it at some length.

First type, *ulatrophia*: is a wasting or diminution in the size of the gingival tissues. Of this type there are four sub types, Ischemic, Calcic, Afunctional, and Traumatic. Ischemic is non-inflammatory and is a true atrophy. It is a diminution in the size of the gingival tissues without recession. Deficiency in blood supply brings about this condition; however, the elements of the blood may be normal. Massaging of the tissues is the treatment for this type.

Calcic presents nearly a true type of atrophy with but little inflammation. The cause, being the formation of salivary calculus in neglected mouths. Removal of the calculus and proper use of the toothbrush constitutes the treatment for this type.

Afunctional is characterized by a slight thickness and increased redness in the marginal gingiva. The fundamental characteristic of this type is subnormal tissue tone due to lack of function. If the teeth are caused to function properly, the gingiva will usually return to normal.

Traumatic: In this type we have a dissolution of the alveolar crest without inflammation. Traumatic occlusion is the cause and its correction constitutes the treatment for this type.

The second type of periodontal diseases is chronic gingivitis. This is possibly the most prevalent of all types. It is defined as an inflammation of the marginal and cemental gingiva. There may be bleeding upon slight injury and tenderness to touch. Redness is usually present. Its etiology is bacterial invasion following mechanical irritation. Removal of the irritations such as traumatic occlusion concretions, restorative impingements, etc., will allow the tissues to return to normal.

The third type of periodontal disease is alveoloclasia, and is defined as the absorption of the alveolar crest and inner wall of the alveolus. There is but one cardinal symptom of this type, mobility of the tooth. No pus is present, no color changes and no particular tenderness of the tooth. The cause is afunctional or traumatic

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\*Read before the Staff Meeting of the Duval County Hospital Sept. 15, 1925.

occlusion. Correction of the causative factors and the tooth will usually return to normal.

The fourth and most pronounced type of chronic periodontal diseases is periodontoclosia or pyorrhea. It is defined as that type of periodontal disease characterized by a solution in continuity of the pericementum and absorption of alveolar bone without loss of the original overlying tissues. The cardinal feature of this type is the formation of the so-called pus pocket.

Generally speaking the presence of pus in the periodontal tissues is less harmful to the system than the presence of pus at the apices of the teeth. The reason lies in the usual free drainage provided for by the lesion through the agency of the gingival crevice. The fact of this exudation usually indicates minimum absorption into the circulation.

Relatively speaking, pus taken into the stomach is less harmful than if taken up by the circulation. Its continued presence, however, is not to be tolerated and whenever present in the slightest, should be considered from a standpoint of fecal infection.

As to the effect of periodontoclosia on general health surely we have been able to see its relationship. Hartzell has pointed out that if each of the thirty-two alveola and thirty interdental spaces were affected to a depth of one-fourth inch, this involvement would be equivalent to an ulcerating surface of seven and one-fourth square inches. Certainly if such ulceration occurred elsewhere on the body surface, treatment would be urged. One-fourth inch necessarily would mean the presence of considerable periodontoclosia, but a much less depth could be present and yet considerable space would be involved. This illustration alone shows what we may expect from a standpoint of involved tissue.

The exact cause of periodontoclosia thus far remains unidentified, although a great many efforts have been made to determine it specifically. It is the opinion of most authorities that no single factor produces the disease; on the other hand it is a combination of factors. In one case it may be due to the presence of a certain factor, in another case another factor and in still another it may be due to the presence of two or more factors.

Of these factors, mechanical irritation is possibly the one that produces the most harm. This irritation may come through incorrect type of restorations, traumatic occlusion, surface abnormalities and restorative impingements.

The type, nature and application of the restoration certainly plays a great part in producing periodontoclosia. When we realize that every restoration placed in the mouth is either for the preservation of health or promotion of disease, it at once fixes the responsibility as to the kind of restoration for a given case. When a dentist uses his favorite restoration in as many cases as possible just because he has become mechanically skilled in constructing this particular restoration and neglects a careful study of the underlying tissues, he has lost sight of prevention. The first and foremost thought that should come to the dentist's mind, is what kind of restoration will give the patient the greatest amount of service and at the same time preserve the health of the underlying tissues.

The gold shell crown and amalgam filling still have their place in dentistry, however, very limited. Cast gold and baked porcelain restorations are fast taking their places in the hands of skilled operators. Not only are these restorations better from a standpoint of lessening gingival irritation, but the normal anatomy of the tooth can better be reproduced in the materials. Tooth anatomy has much to do with the health of the surrounding or investing tissues.

Careless or incorrect mouth toilet occupies a most important place. It has been said that at some time in the history of all cases of advanced periodontoclosia the mouth toilet has been neglected. The presence of bacterial colonies about the teeth are to be considered in certain cases as a primary factor and always a contributing factor.

The treatment for periodontoclosia constitutes the removal of the cause or causes. Careful instructions to the patient as to the care of the mouth is most important. If proper diagnosis has been made and treatment instituted correctly with consideration to the general health, the success or failure of the case depends on the carrying out of instructions as to the care of the mouth by the patient.

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#### A NOTE ON THE TREATMENT OF A SPASTIC COLON

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The colon encountered in the vagotonic type of patient is most easily diagnosed by the X-ray examination following an ingested barium meal.



or a rectal barium enema. This condition is characterized by segmental zones of filling defects which may be proven in a certain percentage of cases by a therapeutic means to be due to spasm. The differential diagnosis lies between the spastic and atonic colons.

During the past two years there has been gradually evolved a routine which has given excellent results in the medical treatment of the spastic types. Routinely, these patients are carefully gone over, and the different focal points of infection eliminated. They are subjected to daily diathermia, sedative in character, together with atropine and bitter cascara sagrada. The atropine is prepared in a four-ounce mixture of lactated pepsin containing 1/400 grain of atropine per dram, the patient taking a dram t.i.d. The exact doses of cascara necessary for a daily semi-solid stool is established, but after a few days this dose is gradually lessened by one drop per day until it is entirely done away with. The only point made in diet is that the food intake be sufficient in roughage.

In the condition of true spastic constipation, failure to get a satisfactory result by following out this method is very uncommon. The time necessary before the treatment may be entirely discontinued depends upon the individual case. One of the most satisfactory results came in a patient who apparently had the most difficult outlook: a male, age 78, who gave a history of having taken various cathartic pills daily for at least fifteen years. He did not take them by count, but by the handful. When he presented himself, his chief complaint was recurring colicky pain in the left lower quadrant of the abdomen. This pain varied in severity, with a history of frequent attacks over a period of years. A barium meal in the sigmoid area gave a string-like shadow of the colon; a barium enema gave the same result. He was subjected to the above outlined treatment for two weeks. At the end of this period his X-ray examination was very satisfactory. The sigmoid was free from spasm and there were eighteen distinct diverticulæ of the sigmoid clearly outlined. Occasionally he has had to renew his treatment for a week or ten days, but for the better part of the past year his bowel has acted daily without any other medication and he has been free from pain.

While there is nothing new in each of the three agents involved in this treatment, it is possible that their synergistic action deserved mention.

## SOME OBSERVATIONS AND CONCLUSIONS BASED UPON FIVE THOUSAND NON-SURGICAL DRAINAGES OF THE BILIARY TRACT

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After a clinical experience, embracing the above mentioned number of non-surgical drainages of the biliary tract, certain conclusions—perhaps convictions—have been reached, which the writer will attempt to briefly summarize.

First: No physician can expect to obtain a high percentage of good results, which should last for several months or several years, unless he is completely "sold" on the value of this procedure in proper conditions, and is willing to infuse into his efforts a thoroughness and sincerity. A careless or indifferent technic, a mental attitude that would "dam it with faint praise", or its use in certain states, to be later mentioned, will result in disappointment to the patients, perhaps discouragement to the physician.

Second: Chronic cholecystitis or choledochitis, generally indicated by flatulence, digestive distress, a "muddy skin", lack of appetite, perhaps a history of malaria or influenza—such a syndrome, known under the rather loose term of "biliousness", which is used for the lack of a better word, offers a promising field for non-surgical drainage. Many of these patients have associated troubles, as chronic appendicitis, gastric or duodenal ulcer, pericholecystic adhesions, etc., which gall-tract drainage cannot cure; but that part of the pathologic picture depending upon an infected gall-bladder or ducts, generally yields promptly to this treatment.

Third: Biliary stasis, with chronic infection of the gall-bladder following malaria, typhoid, constipation or some focal infections may properly receive this treatment.

Fourth: Sick headache cases are either greatly benefited or practically relieved by this method, though in migraine of long standing, quite a number of drainages will probably be required, and the course of treatment may need to extend over a considerable period of time. As many cases of chronic migraine have, to a greater or lesser extent, caused semi-invalidism for years, the sufferer is generally willing to faithfully follow out this procedure, for often it offers the best chance of relief.

Fifth: Some forms of asthma, where the sen-

sitization tests have not worked out satisfactorily, and where it seems probable that the underlying cause of this asthma abides in an infected gall-bladder, will give remarkably good results from biliary drainage. Many asthmatics are nearly desperate, and it can do no harm to try this, though a certain percentage will yield no results.

Sixth: As an adjunct to other therapeutic measures, it is worth while in infectious joint troubles, though quite a number of drainages may be found necessary.

Seventh: In chronic catarrhal jaundice, where there is no material obstruction, such as a stone in the common duct, or a hydrops interfering, this method will frequently yield brilliant results. Occasionally, a colic will follow, and in a few instances, the ejection of small gall-stones has been accomplished. In one instance, the ejection of a large gall-stone followed a biliary drainage. This was duly reported and published in the *Journal of the A. M. A.*

Eighth: Patients with gall-stones can be made much more comfortable by these drainages, whether or not the gall-stones are later removed by surgery. Even after gall-stones are removed, it will be found helpful to have several drainages a few months after the operation. The writer has had a number of such cases in which biliary drainages were administered, pre- and post-operatively, and in every instance they seemed appreciative of the comfort derived.

Ninth: The writer believes that this method would be in order as a pre-operative measure in nearly all of the operations upon the gall-tract, though he has been unable, so far, to obtain much cooperation along this line from the surgeons.

Tenth: There are many patients who have had surgical gall-tract drainage, or have had the gall-bladder removed without permanent relief. Such patients may generally expect a liberal

measure of relief from non-surgical drainage; and some, under the writer's observation, seem to have attained perfect health, where surgery had proved unavailing.

Eleventh: In a certain proportion of gall-tract disease, surgery may be indicated, but for various reasons, may be inadvisable or inexpedient. Many of these cases can obtain amelioration of disagreeable or painful symptoms, with no risk. The writer has had under his care a number of aged individuals who were unable to withstand surgery, and in nearly every instance, gall-tract drainage has proved itself worth while.

The assumption that this method will remove gall-stones, will break up adhesions, will cure appendicitis or cancer of the liver, or remove deep-seated organic pathology of the gall-tract, is unwarranted, and the patients should be so informed. In a number of cases, the writer has been placed in an embarrassing position by having referred to him, by enthusiastic believers in this procedure, unsuitable cases, which non-surgical drainage could not hope to benefit.

Furthermore, in the opinion of the writer, no physician should employ this method unless he enters into it whole-heartedly, performing it in a technically correct manner, and is willing to persevere in his efforts, regardless of either active opposition, or lack of approbation from many of his confreres, whose good opinion he desires.

While neither the principle nor practice of non-surgical drainage is as yet universally accepted, there is, nevertheless, a growing number of conscientious physicians, who are properly employing it, and obtaining satisfactory results.

In conclusion, the writer is convinced that this procedure will enjoy a wider and wider acceptance as its merits become better known, and its limitations better understood, and that it will eventually reach a proper and honorable place as a recognized therapeutic procedure.

FIFTY-THIRD ANNUAL MEETING OF  
THE FLORIDA MEDICAL ASSOCIATION  
WILL BE HELD AT  
GAINESVILLE, May 3rd, 4th and 5th.

## PUBLIC HEALTH LABORATORY EXAMINATIONS AND THEIR LIMITATIONS\*

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The rapid increase in scientific knowledge during the past twenty-five years and the refinement in technique, which makes it practical to perform routinely and in large numbers many tests that previously were only possible in the larger scientific centers in the United States, has greatly increased the scope of Public Health Laboratory work. The function of the Public Health Laboratory is a dual one: it must be in a position to provide the health authorities with comparative statistical data from which the efficiency of various epidemiological procedures can be checked, and it must exercise its diagnostic function for the use of the practicing physician, who should, however, use this privilege only for the detection, or rather, aid in detection of acute infectious diseases or other morbid conditions, the spread of which can be controlled by preventive measures.

Bearing in mind the usual routine procedures carried out in board of health laboratories, we shall proceed with the discussion of the various problems with which the executive must contend. He must keep before him the fact that the laboratory is a public institution and must be prepared to give prompt and efficient service at all times, regardless of any emergency which may arise. This needs no discussion here, as it is purely an internal problem which is overcome by a properly balanced personnel, both office and technical, working under a system of receiving and recording adequate to the particular needs, but elastic enough to cope with emergencies.

The three sources of most of our difficulties are: (1) improper collection of material for examination; (2) failure to give proper data and (3) failure properly to interpret the results.

The laboratory should not be expected to secure results from material unfit for examination. If the condition of the patient is such that a laboratory examination is deemed necessary, it is certainly worth the effort required to submit a proper specimen with sufficient data. Neither

should the laboratory be called upon for the final decision, but the result, as received by the physician, should be considered only in the light of an additional symptom and checked carefully with the other clinical findings. The laity and, we are sorry to say, in many instances the profession, are prone to regard a laboratory as a place to obtain definite decisions, positive or negative. For this reason we have to as large an extent as possible dropped these terms in reporting. A consideration of the various examinations undertaken in board of health laboratories will tend to impress these important facts.

### WASSERMANN REACTIONS

Very little of our former difficulties, in respect to the manner in which samples are received, remain. Certain points, however, are worthy of note. The familiar Keidel tube solves all the difficulties, but its distribution by boards of health is prohibited by its cost. We use a sterile, cork-stoppered test tube in our outfit and send the following directions:

"About 5 c.c. of blood or spinal fluid should be collected in a sterile or dry, chemically clean container. If a syringe is used it should be rinsed in sterile physiological salt solution. Do not use water to rinse syringe or tubes."

In the interpretation of the results we still experience considerable difficulty and are called upon, not infrequently, to state definitely whether the patient has or has not syphilis. In Public Health Laboratories, where we necessarily do not come in contact with the clinical aspect of the case, it is unjust to expect us to pronounce this sentence. The reaction is not biologically specific, but is dependent upon certain substances found in the blood in syphilis and occasionally in other infections. We cannot, therefore, do more than report the actual result of the test to the physician. Nevertheless, the laboratory should give as much information as possible.

Beginning with November 1st, 1925, we have instituted Kolmer's standardized method, a primary ice box fixation using only one antigen. Kolmer's antigen is a specially prepared cholesterolized and lecithinized alcoholic extract of the powdered muscle of several hearts, and in his hands and others has been proven to yield more specific results, being highly antigenic and having very low anticomplementary properties. Our reasons for changing to this method are:

\*The subject matter of this paper was read before the Southern Medical Association in 1922 and published in the Southern Medical Journal in 1923.



(1) That from the evidence at hand this test has proven to yield less false positive and more accurate results from a specific standpoint.

(2) That the technique is such that it lends itself more readily to the routine of the public health laboratory.

#### THE DIAGNOSIS OF TYPHOID, PARA-TYPHOID FEVERS AND DYSENTERY

With the wise use of typhoid and para-typhoid vaccine the positive value of the Widal reaction has been greatly reduced, as it is certain that in a great many instances agglutinable substances are formed in reaction to it. The usual method of submitting blood for this test is to allow several drops to dry on a slide. In the laboratory, to obtain dilutions, physiological salt solution is added, but not knowing the original volume of the blood the dilutions used are only approximate. Performed in this manner just what can the laboratory conclude? Very little, as we are hampered by an ignorance of the clinical aspect of the case. By far the better method of submitting samples for a Widal reaction is to obtain in the same manner and a like quantity as for the Wassermann test. With sufficient serum at our disposal we can make accurate serial dilutions and titrate the amount of agglutinable substances present. It is reasonable to suppose, in an actual infection with either the typhoid bacillus or one of the para organisms, that the agglutinins will show a much higher titre than following vaccination. In fact, Strauss of Richmond, Virginia, has found that the titre following vaccination rarely exceeds 1-50, and false agglutination is eliminated at 1-100. It must be remembered, however, that it is possible for a person to have a typhoid infection without being able to demonstrate agglutinins in the blood at any time. The Widal reaction is not a test for typhoid fever, but is used to determine the presence or absence of typhoid agglutinins from which certain conclusions can be drawn.

Bearing these facts in mind, it is readily seen that the laboratory, by limiting its work on typhoid to the Widal reaction, is not doing its full duty. Cultures of the blood, urine, and feces should be instituted. To introduce blood cultures in typhoid diagnosis as a routine procedure would necessitate the authority of selection of cases by the laboratory director, as the immense amount of technical work required could not be applied indiscriminately. A suitable container

for general use consists of a small cork-stoppered bottle containing sterile bile, or bile brilliant green media to which is added about one-half its volume of blood. The inhibiting action of bile and brilliant green on certain organisms, with the fact that it is a favorable medium for the growth of typhoid bacilli, makes this method practical. The chances of obtaining positive blood cultures diminish rapidly after the seventh day, and this fact should be borne in mind in interpretation of results. Urine and feces cultures should be taken not only as an aid to diagnosis, but to determine the carrier state. These may be taken in bile brilliant green medium.

For the diagnosis of dysentery, feces cultures are necessary, but the laboratory should insist on specimens of blood to be examined for agglutinins. Especially is this true in field work on outbreaks of diarrhea when laboratory facilities are poor.

#### BRILL'S FEVER OR TYPHUS FEVER

Occasional sporadic cases of this disease occur in this country. It is therefore well to bear in mind that the laboratory can aid in diagnosis of suspicious cases by performing a Weil-Felix reaction. This is a macroscopic agglutination test carried out with proteus bacilli and the patient's serum. The same quantity of blood as is used for the Wassermann reaction is necessary.

#### THE DIAGNOSIS OF MALARIA

The examination of films for malaria plasmodia requires a satisfactory specimen. It should be taken before the administration of quinin and the time before or after the chill should be stated. Probably more unsatisfactory specimens for malarial examination reach us than any other variety, yet it is a comparatively simple matter to place a drop or two of blood at the end of a slide and with the edge of another make a thin, even film, which is easily stained and gives us a proper field in which we can study not only the character and proportion of erythrocytes and leucocytes, but also discover the presence or absence of malaria plasmodia. The failure to demonstrate plasmodia does not mean that the patient is not suffering from the disease. This is one of the tests which has a positive value, but very little negative value.

#### SPINAL FLUID

In general, what applies to the Wassermann reaction in blood work applies here. All cases

of syphilis involving the central nervous system do not give a blood Wassermann. They may only show a reaction in the spinal fluid, which explains the importance of spinal fluid Wassermann tests.

Cell counting is a very valuable procedure, but it must be remembered that unless they are counted within a very short time after withdrawal, autolysis occurs, and also that a cell count on spinal fluid contaminated with blood is without value.

Results on tests for globulin must be interpreted by the clinician.

Cultures and direct bacterioscopic examinations for the detection of organisms causing meningitis are of great value both from a clinical and public health viewpoint, particularly in the diagnosis of meningitis caused by the diplococcus intracellularis meningitidis, from a clinical standpoint because specific serum can be administered, and from a public health standpoint because the disease being of carrier nature can be readily controlled. Further, the bacterioscopic and cultural examinations of all cases of meningitis will lead to a definite diagnosis, and if the health authorities are not involved, at least their laboratory has proven that further investigation on their part is not necessary.

#### TUBERCLE BACILLI

The proper collection of samples should certainly not be difficult, but after a number of years' laboratory experience we are forced to state that, considering the serious nature of tuberculosis, physicians, nurses and laymen alike do not seem fully to appreciate the dangers in handling tuberculous sputum. It is really amazing to see in how many weird manners sputum can be submitted to the laboratory for examination. We have gotten it in handkerchiefs, in envelopes, on scraps of paper, in milk bottles, in coca-cola bottles, vaseline bottles, ointment jars, opened or closed, partially filled, leaking, filled to overflowing, and so on ad infinitum.

We would urge a more careful handling, not only from our own standpoint, but also for the protection of the physician and his other patients. When the least is said, and leaving out the danger of actual contact with known tuberculous sputum, it is decidedly unpleasant to have to come in contact with sputum of any kind.

The bacterioscopic examination of sputum is another test which has only a positive value, as

our failure to find tubercle bacilli does not mean that the patient is not tuberculous.

#### GNOCOCCI

In obtaining a specimen from an acute case of specific urethritis in the male there is scarcely anything to be said, but in examining the smears from the female genitalia we have an entirely different problem to face. A vaginal smear for diagnosis is practically worthless, with the possible exception of the not infrequent cases of specific vaginitis occurring in infancy and early childhood. Smears should therefore be taken directly from the urethra, the os cervici, and the orifices of Bartholin's glands.

This test, therefore, has only a positive value, and in as much as in the bacterioscopic examinations we depend only on the morphological and staining characteristics of gonococcus, our reports are worded intracellular diplococci resembling gonococci found or not found, as the case may be.

The technic of cultural isolation of the gonococcus is such that it is impractical to introduce it as a routine measure in public health laboratories.

The affinity of the gonococcus for the conjunctiva makes it imperative to examine very carefully all cases of suppurative conjunctivitis.

#### DIPHTHERIA

A public health laboratory plays a rather important role in this disease. Not only are we called upon to make diagnosis of actual cases, but also to determine the presence of carriers among the contacts of known cases that steps may be taken to prevent widespread epidemics. It must be remembered that while it is permissible for the laboratory to state that a culture is either positive or negative, this report must not be taken to mean that the patient has or has not diphtheria.

Tests for the virulency of diphtheria bacilli are of great value in releasing from quarantine chronic carriers whose throats and nasopharynxes persistently show positive cultures despite vigorous treatment, including at times tonsillectomy.

#### RABIES

This disease, if contracted, is, as far as we know, always fatal. In view of this fact the examination of animal heads submitted assumes tremendous importance, especially in our state,

where the incidence of rabies is high among animals.

We feel that we have more difficulty in handling this question satisfactorily than in any of our other procedures. So much superstition surrounds this subject not only in the minds of the laity, but among the profession. The status of diagnosis is this: that if Negri bodies are found in fresh brains the animal is rabid. If suspicious bodies are found in fresh brains it must be considered rabid, and if suspicious bodies are found in partly decomposed brains it should be considered rabid. This seems easy enough and it certainly settles the question from a positive standpoint.

Unfortunately, the usual thing done in cases where people are bitten by animals is to kill the animal immediately and submit its head for diagnosis. Our opinion is the examination of the brain in such cases is a useless waste of time, but here we face this difficulty: that an animal showing definite symptoms of rabies and killed immediately will usually show Negri bodies. We realize also that at times it is not possible to catch an animal and pen it up. Nevertheless, in going over the history of animals whose heads have been submitted for examination, we find that a large number are killed which show absolutely no symptoms of rabies. What are we going to tell the patients when our examination fails to reveal any evidence of rabies? Just this: that if the animal died it was probably not rabid, but if it was killed we cannot give any opinion whatever or any advice from the laboratory evidence alone as to whether the patient needs the Pasteur treatment or not. In instances of this kind a careful investigation into the actions of the animal before death is essential before advice can be given.

The proper procedure in cases of animal bites is to quarantine the animal for a period of 10 days. While it is advisable to begin treatment at the earliest possible moment, it is probably safe to expect that if treatment is begun within ten days it will be effective.

#### FECES

The collection of specimens of feces to be examined for ova or parasites is very simple, but certain features are worthy of mention.

(1) It is not necessary to procure a large sample, and unless the patients are definitely in-

structed in this respect, they will frequently bring in enormous quantities.

(2) Formed stools are to be preferred for the following reasons: they are usually less malodorous than fluid stools, gas does not form so readily and blow out the stoppers from the containers.

The inability to find ova or parasites in one specimen does not preclude the possibility of infestation of the intestinal tract with parasites.

The examination of feces for endameeba histolytica is only possible with absolutely fresh specimens. It is advisable to send the patient to the laboratory. If this is not possible the sample should be kept at body temperature until examined.

#### DAIRY PRODUCTS

This is a problem which confronts only the health officer, and all that need be said is that chemical tests are so much more definite than the various bacteriological procedures that the results obtained can be judged by the experience of the chemist performing them. As to the proper collection of samples for bacteriological examination little need be said. If the products are delivered in bottles, unopened bottles should be obtained. If the samples must be taken from a large can, the contents should be thoroughly mixed by means of a sterile stirrer, and at least 10 c.c. should be taken by means of a sterile pipette into a sterile container.

#### WATER

Board of health laboratories are called upon to make chemical analyses of water from a sanitary standpoint. The minimum quantity needed for this analysis is 2 litres. The result of a sanitary chemical analysis of water must be interpreted only in the light of additional knowledge gained by a field survey of the water shed or local conditions, and a knowledge of the character of waters from that locality.

In the collection of samples of water for bacteriological examination, 100 c.c. is sufficient for the ordinary routine official plate count. Samples for bacteriological examination should be taken in sterile, glass-stoppered containers of the proper capacity, supplied by the laboratory doing the test.

The following rules obtain for the length of time which may be allowed to elapse after taking the sample and the beginning of its analysis:



## Chemical analysis:

Ground water .....	72 hours
Fairly pure surface water .....	48 "
Polluted surface water .....	12 "
Sewage effluents .....	6 "
Raw sewages .....	6 "

## Bacteriological examination:

Samples kept at less than 10° C...	24 "
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## CONCLUSIONS

In conclusion, let me state a few broad principles which will prove of value to the physician, health officer and laboratory alike:

- (1) Submit properly obtained samples.
- (2) Give as much data as possible.
- (3) Bear in mind that a great many tests have only a positive value.
- (4) Interpret laboratory results only in the light of other clinical findings.

## SMALLPOX

B. L. ARMS, M.D.,

*State Health Officer*

The physicians of Florida can do a great work for the state as well as their own community if they will strongly urge everyone of their patients to be vaccinated.

Smallpox has appeared in all parts of the State, nor is it confined to this State. Several of the other States having more cases than Florida.

There is no reason why we need have smallpox and if we all pull together and get the citizens of the State vaccinated we will not have it.

We are making good headway now, but we need the cooperation of every physician in the State, not only doing vaccinations but preaching vaccination.

517 cases were reported December 1, 1925—February 6, 1926, and over 150,000 vaccinations have been performed.

Any physician can obtain vaccine virus by applying to the nearest State Laboratory, but any large request should be made direct to the Laboratory at Jacksonville, which is the main distributing point. VACCINE VIRUS IS NOT SENT TO THE ANTITOXIN STATIONS BUT MUST BE ORDERED DIRECT BY THE PHYSICIAN DESIRING IT.

In requesting virus please state amount desired, for we cannot tell how much is wanted

when we get a request for a "supply" or "some vaccine".

Vaccine virus should be properly kept or it will lose its potency, hence you should not order more than is needed, and when received it should be kept in a refrigerator until you wish to use it.

Vaccination is the only means of stopping the spread of smallpox, and I am sure every physician in the State is vitally interested in stamping out the disease.

Please report cases promptly, for we must know every focus in order to do our most effective work, and the earlier we learn of a focus the more prompt the action that can be taken.

It is much better to take steps to avoid cases than to wait until cases have appeared, hence every community should put on an intensive vaccination campaign.

Our medical men are doing all in their power to limit the spread but need the assistance of each physician in the State to help, and in helping the State they also help their own community and their own patients.

Following is a summary:

CASES OF SMALLPOX REPORTED DECEMBER 1, 1925, TO FEBRUARY 6, 1926, INCLUSIVE, BY COUNTIES AND CERTAIN CITIES

Location	December	January	Feb. 6th	Total
State .....	65	322	130	517
Alachua .....		2		2
Bay .....		1		1
Brevard .....		10		10
Broward Ex. ....			2	2
Ft. Lauderdale .....		1	3	4
Citrus .....			1	1
Columbia .....		14		14
Dade Ex. ....		2	2	4
Miami .....	25	82	38	145
Duval Ex. ....			4	4
Jacksonville .....	13	35	29	77
Escambia Ex. ....	1	4		5
Pensacola .....	1	1		2
Gadsden .....		2		2
Highlands .....	3		2	5
Hillsboro Ex. ....		10		10
Tampa .....	13	122	23	158
Jefferson .....		1		1
Leon .....	1	2		3
Levy .....		1	1	2
Manatee .....	1	2	1	4
Marion .....		5		5
Orange Ex. ....	1	7		8
Orlando .....				
Palm Beach Ex. ....		3		3
West Palm Beach .....			20	20
Pasco .....		5	1	6
Pinellas Ex. ....	3	3	1	7
St. Petersburg .....			2	2
St. Johns .....	1			1
St. Lucie .....		3		3
Santa Rosa .....	2			2
Sarasota .....		1		1
Seminole .....		1		1
Union .....		1		1
Volusia .....		1		1

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## MODERNIZING HOSPITALS

It is pleasing to note the interest in hospitals as  
manifested by news items appearing in the  
Journal pertaining to the progress of hospitals  
throughout Florida.

A survey of hospitals of the United States re-  
veals that there is one hospital to each seven hun-  
dred square miles of territory. Two years ago  
there was only one hospital to each fourteen hun-  
dred square miles of Florida territory. It was  
further noted that sixty-seven per cent of the  
counties comprising the state of Florida were  
without hospital facilities.

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Monroe.  
TWENTY-FIRST DISTRICT—DR. H. D. CLARK . . . . . Ft. Pierce  
St. Lucie, Okeechobee, Indian River, Martin.

At the present time many hospitals are being  
planned throughout the state.

In the principal centers the hospitals that have  
existed for a number of years have adopted a  
standardized plan of operation under the re-  
quirements as laid down by the American Col-  
lege of Surgeons and under conditions which  
grant a grading at the hands of the American  
Medical Association indicating that certain hos-  
pitals are qualified for the training of internes.

In several hospitals there are training schools  
for nurses operated under the standardized pol-  
icies of the National Nurses' Association and  
some have been successful in gaining recognition  
as being in accordance with the requirements of  
the New York State Board of Regents for the  
operation of nurses' training schools. Nurses  
graduating from training schools that are prop-  
erly standardized may practice their profession  
in New York state, and are qualified for nursing

services in the different governmental activities, particularly the medical department of the Army and Navy.

Under the present plan of standardized hospital operation the physician to qualify for the privileges of the hospital, is required to have received a diploma from a Class A medical school, and to have served an internship of one year in a recognized hospital. With this experience doctors are qualified for the medical privileges only. If an applicant desires the extension of the surgical privileges he must have had, in addition to the above, a year's assistantship in surgery in association with a surgeon of recognized ability; a second year internship devoted to surgery is regarded as the equivalent to a year's assistantship to a surgeon of recognized ability.

In the city of Jacksonville it is noted that the new County Hospital pursues its already established policy of a permanent staff organization and that St. Vincent's Hospital adopted the permanent staff idea some time ago. It is announced that St. Luke's Hospital has adopted the permanent staff plan of operation. A permanent staff organization does not indicate a self-perpetuating organization, but that the appointments, although permanent, are subject to modification by an executive committee consisting of laymen.

In contrast to the situation in the past, hospitals that are now standardized have as an underlying principle to operation a policy which guarantees the patient against incompetency and neglect. Doctors are required to demonstrate their fitness. It is no longer possible for a physician by virtue of being a doctor of medicine, to undertake the performance of grave surgical and other procedures until such time as he shall have demonstrated his fitness. The public is beginning to realize that with standardized education the ability of one doctor as compared to another is more or less equal and that the results in the treatment of human illnesses depends very largely upon the instruments which the public places in the hands of the doctors with which to work, namely, well equipped and well organized hospitals.

Florida can proclaim to the world at large that its public health activities in all directions are comparable in a most satisfactory manner with the facilities offered elsewhere.

## STATE NEWS ITEMS

At a recent meeting of the Pinellas County Medical Society the following officers were elected: Dr. T. R. Griffin, president; Dr. L. A. Wylie, vice-president; Dr. H. L. Putnam, vice-president; Dr. O. O. Feaster, secretary; and Dr. E. Lustig, treasurer.

Dr. J. Knox Simpson of Jacksonville read a paper before the Southern Section meeting of the American College of Surgeons held in New Orleans last month, the title of which was "Syphilis of the Stomach," with lantern slide demonstrations.

The annual election of the Dade County Medical Society was held December 4 and the following officers were elected: Dr. R. O. Lyell, president; Dr. G. Rapp, secretary; Dr. R. C. Woodard, vice-president; Censors, Dr. W. S. Coleman (? years), and Dr. J. A. Simmons (3 years).

Dr. H. Mason Smith of Tampa was a recent visitor in Jacksonville.

The following Florida members of the American College of Surgeons attended the Southern Section meeting held in New Orleans last month: Dr. Frederick Waas, Dr. Gerry Holden, Dr. E. H. Teeter, Dr. J. Knox Simpson and Dr. Shaler Richardson, of Jacksonville, and Dr. C. F. Sayles of Miami.

Dr. John S. McEwan, President of the Florida Medical Association, addressed the St. Lucie and Marion County Medical Societies during the past month.

February first marked the opening of the Diagnostic Laboratories in Jacksonville. The Diagnostic Laboratories are under the management of Dr. W. W. Kirk and Mr. E. W. Moore.

Dr. Kirk is Director of the Clinical Laboratory of St. Luke's Hospital and Pathologist to the Duval County Hospital, St. Vincent's Hospital and United States Veterans Bureau, Jacksonville. He was formerly Assistant Director of the Philadelphia City Board of Health Laboratory, following graduation from the University of Pennsylvania and hospital service in the Philadelphia General Hospital.

Mr. E. W. Moore was formerly Laboratorian



in charge of the United States Veterans Bureau Hospital No. 63 in Lake City, for nearly four years, and prior to that time was Chief Pharmacist's Mate, performing Laboratory duties in various Naval Hospitals in this country and abroad.

The Diagnostic Laboratories are fully equipped for all routine and special examinations pertaining to serological, bacteriological, pathological and clinical diagnosis.

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Dr. M. M. Andrews, Secretary-Treasurer of the Orange County Medical Society, filed the first roster, showing members in good standing and also a check covering dues for each member.

The success of the State Medical Association depends largely on the activities and efficiency of the county societies. The Orange County Medical Society has certainly set the pace in establishing the standing of the members on its roll for 1926, and we believe their example will be followed very soon by each county society in the State of Florida. Congratulations to the Orange County Society.

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The following interesting item has been forwarded to the Journal by Dr. Fred J. Walter of La Mesa, California:

Copy of a dentist's announcement appearing in the Virginia Gazette and Alexandria Advertiser, published Thursday, April 18th, 1793, a copy of which paper I have at the present time. As printed:

W. P. Greenwood, Surgeon-Dentist,

Pupil and Son to the celebrated Dentist of that name at Boston. Respectfully informs the Ladies and Gentlemen of this City and its vicinity, that he purpofes tarrying here a fhort time to practife in the line of his profeffion.

He will with plefure receive the commands of thofe who wifh him to perform any operation in the Art-Dental, fuch as cleaning the teeth, eradicating the diforders incident to the gums; extracting, tranfplanting, plumbng and regulating the teeth; alfo fixes in teeth, from a fingle tooth

to a whole fet, that will vie in beauty with the moft brilliant natural ones; and if not done to the fatifaction of the patient, he requires no pay.

N. B. Mr. Greenwood may be confulted with at Mr. Mark Edgar's, Fairfax-Street, and will wait on Ladies or Gentlemen at their houfes, if moft convenient.

Alex. April 10, 1793.

194—3 w.

Note that the letter s is as f except when final.

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### EMORY UNIVERSITY TO RAISE \$4,500,000 FOR MEDICAL EDUCATION

Medical education is to receive a total of \$4,500,000 from the \$10,000,000 Expansion Fund now being raised by Emory University, Atlanta. This money will be distributed as follows: Endowment for the School of Medicine, \$2,000,000; endowment for the Wesley Memorial Hospital, \$2,000,000; pathology laboratory and hospital administration building, \$225,000; nurses' home, \$200,000; completion of chemistry building, \$15,000. The goal of the campaign as a whole is to provide \$6,500,000 in endowment and \$3,500,000 in new buildings to cover the estimated needs of all six schools of the University for the next ten years.

The Emory School of Medicine, formerly the Atlanta Medical College, has long been one of the three largest and strongest A-grade medical colleges in the South. It has a total of 3,400 alumni now practicing in all states of the union but two. Dr. Russell H. Oppenheimer is dean of the faculty of 130 men, among the part-time members of which are some of Atlanta's most eminent physicians and surgeons.

For many years the school has been handicapped both in research and teaching work because of inadequate endowment. The enrollment in each class has been limited to sixty men at a time when more physicians of Georgia alone are dying each year than the two medical colleges of the state are graduating. The school is looking to its alumni and to the other friends of medical education to give the funds so urgently needed for expansion.

## ABSTRACT DEPARTMENT

## ROENTGENOLOGY

Roentgen Treatment of Chronic Cough in Children. Mulford K. Fisher. *The American Journal of Roentgenology and Radium Therapy*, September, 1925, Page 244.

In 1903, Heinike first published the results of his experimental work on the effects of roentgen radiation on lymphoid cells and structures, proving definitely the retrogressive and destructive action induced by roentgen ray on glandular tissue. Clinical application of these classical studies furnished the basis of treatment in these cases of persistent, chronic coughs in children.

The same principle applies in the treatment of thymus disease. This treatment has grown to be one of the outstanding specifics in pediatric practice. The relief afforded, sometimes, by only one exposure, is so marked that it borders on the dramatic.

A group of cases presenting a dissimilar pathology, but clinically and etiologically very much alike, are mediastinitis and peribronchial adenitis. Holt gives a classical description of the symptomatology of inflammation of the bronchial lymph nodes. "Cough is hoarse, persistent, teasing and frequency occurs in paroxysm which resembles pertussis but lacks the whoop and is not accompanied by the expectoration of a mass of tenacious mucous." This group of cases is usually amenable to roentgen treatment.

One of the real difficulties besetting the path of pediatricians is the treatment of chronic, persistent cough. It is by no means an uncommon condition and constitutes a class of cases trying the physician's skill, diagnostic acumen and patience.

Roentgenographic study of the chest presents no typical findings. Nearly all of them present a peribronchial fibrosis or some scattered bronchial or mediastinal lymph nodes which are enlarged. These are such constant findings in children's chest that slight importance should be placed upon them.

Clinically, these children resemble more closely a non-productive chronic bronchitis than any other clinical entity.

The results from roentgen therapy in this type of case have proven highly gratifying. Complete cessation of the cough is obtained in practically every instance. The treatment consists in giving a small stimulating dose of filtered radiation,

weekly or at ten-day intervals. Often a cough begins to subside within 48 hours after the first treatment.

To explain the "modus operandi" of radiation in clearing up these so-called idiopathic coughs in children would be pure theorizing. Whether a thymic influence keeps up the irritation or the presence of one or more bronchial lymph glands, so situated as to cause pressure on the vagus or its branches, is problematical. In either or both instances the effects of the roentgen ray is explainable on the hypothesis of the influence of radiation on lymphoid tissue. Whatever the cause, the results have been sufficiently encouraging to warrant the continued use of roentgen radiation in this class of patients.

W. McL. S.

## DERMATOLOGY.

Mycosis Fungoides. Its Relation to Leukemia and Lymphosarcoma. J. Frank Fraser, M.D., Instructor in Dermatology, Cornell University Medical School, N. Y. Abstracted from *Archives of Dermatology and Syphilology*. Vol. 12, No. 6.

The history and histo-pathological findings in two human cases of mycosis fungoides and a case of lymphosarcoma in a South American squirrel are described. A leukemic blood picture in the disease is rare, but cases have been reported. It is suggested on morphologic grounds that the lesions of mycosis fungoides arise from the reticulo-endothelial cells of the skin.

Summary is quoted from the article.

Two cases are added to the growing number of instances of mycosis fungoides in which the pathologic changes in the tissues are unquestionably neoplastic.

Evidence is presented which shows a genetic relation between mycosis fungoides, lymphatic leukemia and lymphosarcoma.

The name reticulum cell sarcoma is suggested to replace the term lymphosarcoma in designating the lesion of mycosis fungoides. The suggestion is based on the assumption that the lesion has its origin in the reticulum cells of the papillary layer (reticulo-endothelial system of the skin).

J. L. K. S.

## OUR NATIONAL DOCTOR'S BILL THE PUBLIC'S DEBT

*It has been computed by conservative physicians that 40% of their service is gratuitous either through voluntary service or through clients failing to pay the doctor's bill. Over \$135,000,000 in charity service given annually.*

A cursory survey of the gratuitous service given by physicians through medical institutions in the Greater City of New York, based upon the number of "free hospital days," aggregate \$16,000,000 annually.

This figure by no means indicates the total bill that the city-controlled and private hospitals would have to pay if the doctor, like other professional men, demanded and received payment for each and every service performed.

It is based upon returns from but 107 of the 140 odd medical and surgical serving institutions giving some portion of charity service.

Evaluating the physician's service nationally upon the hypothesis that outside New York City but a pro rata service in quantity is given equal to 50%, and assuming that each "Hospital Day's" service was paid for at the rate of \$3.00 per day, the nation's bill due the doctor would be more than \$135,000,000 annually.

A survey made within the City of New York (by no means complete because many of the hospitals had not their figures at hand for this quick computation) shows the following:

Institutions in New York are roughly grouped into five classes:

Group one and two are the city-controlled hospitals—those operated and maintained by the City Government—and are composed of fifteen institutions, ten of which are under the management of the Department of Public Welfare; the others, known as Bellevue and Allied hospitals, include five institutions.

The third group are those supported in part by the Catholic Charities, of which there are twenty-two institutions. The fourth group is the United Hospital Fund group, which is financed annually, partly through drives, representing fifty-six institutions. The independent hospitals into which class are gathered all those institutions not included in the above four groups compose the fifth group. There are forty odd institutions in this latter group, of which number fourteen have made returns for the purposes of this survey, the other four groups being complete in their returns.

These groups show the following:

Department of Public Welfare group (10 hospitals)	1,879,871	free days	
Bellevue and Allied Hospitals (5 hospitals)	859,232	"	"
Total city-controlled hospitals	2,739,103	"	"
Catholic group (22 hospitals)	322,610	"	"
United Hospital Fund group (56 hospitals)	1,563,658	"	"
Independents (14 hospitals)	395,131	"	"
Total (107 hospitals)	5,020,502	"	"

The total displayed above, 5,020,502 "free hospital days," represents the number of free days' service given to free charity patients in the city's hospitals in a year.

Going a step further, it is no exaggeration to say that each patient is visited at least three times in each "hospital day" by a physician who receives no compensation whatsoever.

If we compute each visit of the physician as being worth a dollar, we find that the bill would be \$15,061,560 per annum.

This includes the services of the consulting and outside attending physicians and surgeons, together with the services of the internes, but it is all medical or surgical service.

In taking three dollars as the equivalent of service of the consulting, attending and interne physicians, we feel we are placing the compensation at a price so far below normal for the compensation for a similar service outside the institutions as to prevent criticism or cavil of any kind.

For, when it is considered that these include the best medical and surgical brains in the country, the most expert men in the profession, who, in some instances are known to charge fees as high as \$5,000 for an operation, and others who charge as low as \$25 for a consultation, and then again those who charge no more than \$3 per visit to outside patients, we feel that we have been almost unfair in the computation of the doctor's bill; but we will let it stand at that figure to show the prodigious sum that annually would be due the doctor if, as I have stated before, he demanded and secured even this small measure of pay for his services in public institutions.

### NOW FOR THE NATIONAL BILL

As New York City represents about 1/18th of the total population of the United States, the national bill would, therefore, be eighteen times



that of the City of New York, but we will not use that figure, because it might be argued by some that the measure of service given throughout the rest of the country is not in the same proportion either in quantity or quality.

Then, there are those who may even claim that the service outside Greater New York by physicians, through similar institutions, is greater, proportionately, both as to quantity and value.

The figure arrived at here is not intended as one of discourtesy to any city or section in any of the states, it is merely taken to arrive at an evaluation of the national service of the physician—as a basis, if you please, for a more thorough evaluation of his services, and with the hope that a national census may be taken which will be thorough, complete and satisfying.

Therefore we will set down as our premise that the balance of the country gives, pro rata, a service of but 50% of that given by the City of New York. This abnormally low computation shows that the physicians' national bill would total \$135,553,554.

If we place the total number of registered physicians at 165,000, nationally, and divide this into the figures above attained, we find that each and every physician in the United States should be credited with \$821 gratuitous service every year.

Of course, every physician is not connected with a hospital or similar institution giving gratuitous service to the poor, and this figure is attained, therefore, by making a spread of the entire bill over the 165,000 registered physicians.

Then, again, it must be remembered that this sum does not in any sense measure the free service of which no accounting ever has been made or ever can be made—of the charity or free service that the physicians give to the poor whom they meet in their daily practice.

Just what this bill would amount to, God only knows, because the physician never keeps account of it, and if you happen to mention it to him, he will laugh it off, saying, "Oh, that's for the good of the service—for the good of mankind."

But there is another element that enters into this question of service, for which the physician never is paid, and this is the most baneful element, the unpaid bills of those who are well able financially to meet their obligations to their physician.

Every family doctor has a number of these every year upon his books, and if the facts and

figures were recorded, of the money lost to the physicians in this way, it would stagger one and give to each a twinge of conscience.

And when one considers that the measure of the physician's service is intimate, personal and means relieving the individual of pain, suffering, the saving of a limb, aye, the saving of a life perhaps, this negligence takes on an aspect that is indescribable.

With this situation well in mind, can there be any question as to why so many physicians eke out meagre existences, and that many—the majority—die without estate, and that many become public charges because of financial distress?

And with the costs of living rising like the tides, is it any wonder that so many of them are engulfed and have to enter almshouses, or that those capable of it have to seek employment in other lines in order to maintain themselves decently?

#### THE MEN OF PURE SCIENCE

Again, there is an aspect to the situation which presents a problem that never can or will be solved in the approach that is being made to solve problems of similar kind these days; that is the problem of the man of pure science—the man who devotes himself to the science of medicine and employs his time digging and delving in the laboratory to seek some panacea for the existent ailments of life, or who, built in more heroic mould, submits himself to the torture of disease through inoculation, that he may record the symptoms, and that his brother physicians may record the progress of disease in him, so that mankind may be benefited as the result of his sacrifices and studies.

To evaluate this service of the physician is something beyond the power of figures, or dollars or cents, because there is the jeopardy of life always, and who can say as to the value of a life given in this manner?

The next element is that of the man who through pure service to the public is stricken down, who has to leave his bed at the call of the patient at unseemly hours; who answers call after call in this manner, totally unmindful of his own physical well-being, knowing only that some one is suffering and that his duty is to relieve that suffering. When this man becomes aged, penniless and is incapacitated from going the daily round of the old family doctor, should there not be some place to which he may go; some place to which his eyes may turn in hope and solace?

And then as to the good wife, who has shared his burdens through life, and whose warnings and entreaties have fallen upon deaf ears, the only call being heard being that of service—what is to become of her? Is she to be sent to the poor-house over one hill, and he to be sent to another over the other hill, and thus these twain parted at a time of life when the affectionate companionship of years should solace their few remaining days?

Is this to be their lot?

What is to become of the vaunted ethics, the service and the pride of the medical profession if this be permitted?

To take care of one's own is a natural impulse; to take care of others is called charity, but to take care of those who sacrifice their health, their strength, their years, their service, in behalf of the public or in behalf of their profession—this calls not for charity, it is a call to duty.

Today there is reported a dearth of physicians throughout the country. There are hundreds of communities where one doctor has to serve many such.

The poor compensation, bad debts, unseemly hours, the personal hazards to health, limb and life do not compensate a physician these days as against other professions, so doctors are becoming fewer, proportionately, in the rural districts.

And this is no wonder, because, according to the American Medical Association, from figures printed some time ago, \$1,000 was the average earnings of a doctor.

And, of course, it is beyond question as to a man being able to support himself, and make his daily rounds on such a basis of compensation—much less to maintain a horse and carriage or an automobile, and a family and a home thereon.

All these problems have been revolving in the minds of certain forward-looking physicians for

several years, with the result that a little experiment, or adventure, was begun up in the hills of Caneadea, New York, where there was established a trial unit of a home for aged and superannuated or ailing physicians and their wives. For four years this institution has been doing its mission of mercy and love, and now the call upon it are so heavy that it seems due the medical profession to found a home, national in scope and service; a place where tranquility will be theirs during their last few years of life.

And, as planned by these physicians, it serves a double mercy in that it does not separate the physician from his good wife and life partner at this crucial time in their existence. Provision is made for both at the home, and the fact that it has worked out successfully adds flowers to the benison.

That this national home had not been thought of before, nor had not been actually started before, is due to the diffidence of the profession in its personal affairs—it did not wish to lay bare to public scrutiny that so many within the profession are needy, or may be in actual want.

But when the facts were laid before some of our leading and far-seeing citizens the reply was instant that something must be done, and that they would sponsor the movement to raise funds for the national home.

Here are gathered a few of the words of encouragement and God-speed, which have created this enterprise, from the pens of leading citizens, this enterprise, from the pens of leading citizens.

If, after reading them, you feel that you would like to help in this great movement by your personal gift, please forward the same by check, drawn to the order of the Physicians' Home, Inc., and mail it to Dr. Albert G. Weed, Treasurer, 22nd floor, Times Building, Broadway and 42nd Street, New York City.

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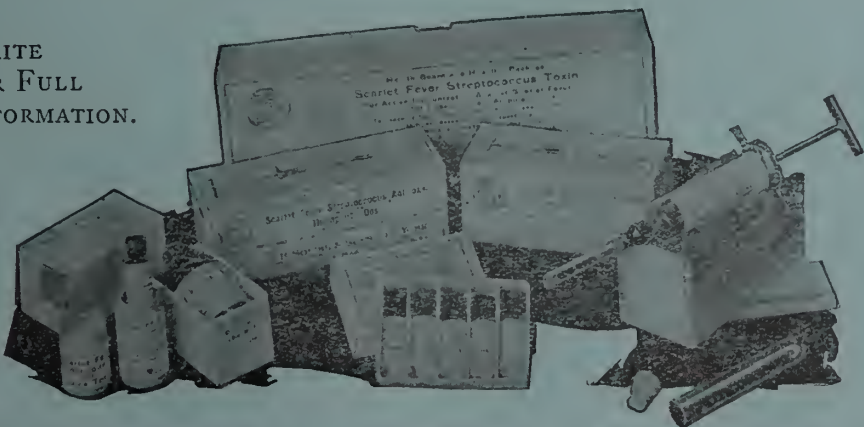
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## ON THE TREATMENT OF COLDS\*

M. A. LISCHKOFF, M.D.,

Pensacola, Fla.

One must be impressed with the lack of progress and the great number of remedies offered for the treatment of colds. Quite frequently we read of experiments performed in different places, almost at the same time, and each arriving at different conclusions. It is then apparent that we lack some vital concept or our journals would not be filled with so many well-meaning advertisements of diversified offerings. For that reason it should be the duty of the profession to attempt to arrive at a better understanding of the pathology, and until we do we should consider colds a phenomena complex and treat them as such.

We cannot accept the bacteriological cause of colds, but must admit that infection plays a definite part. We can even go farther and recommend the use of both stock and autogenous vaccines both as a prophylactic and curative. In many instances, vaccines have given definite cures that had yielded to no other remedy. Climate and seasons have their enormous toll, but that alone does not prove it a cause. It must, however, be considered in outlining therapeutics. Many feel like local pathology in the nose or throat is a very important factor, yet we see many tonsillectomized or other post-operative patients returning for treatment or at least only slightly benefited.

The most logical treatment, even though empirical, would then seem to be general and local as well as etiological. The former would include everything systemic from tonics to eliminants; local would be aimed more at relief of distress, drainage, etc., and the treatment with reference to etiology would be more prophylactic.

Different stages of a cold require different remedies, but there are a few fundamentals that we can all agree upon. A day in bed is one of the most useful yet impractical suggestions one can offer. Yet our adult males do not consider it sufficiently important to warrant a day from business and will only occasionally allow such a

severe remedy to be used. Those of us who recommend a day in bed and a dose of castor oil have often been gratified to find our patients materially improved and all of us look upon that as an excellent method. But catharsis is only of relative importance and purges only help those subject to constipation.

With our heat regulating mechanism, sugar, fat and calcium metabolism affected, it is no wonder that a cold will often respond to one remedy this time and not the next. Probably one important factor is the apparent indifference which patients apply for treatment, because most adults only reach us after their friends, druggists and home remedies have failed.

It would seem that we should attempt to agree on some rational procedure. Why should some prescribe atropin to combat nature when she is making every effort to eliminate by stimulating secretions, while others use one of the common older treatments consisting of hot baths to produce diaphoresis? In fact I know of no procedure that has given me the quick relief of hot or Turkish baths, and I feel like hot baths, cleansing of sinuses with negative pressure followed by nasal astringents, vapors, e'c., will at least make my patients feel better. To that we may add alkalinization, aspirin or other salicylates and occasionally urotropin. These increase relief tremendously. After that it resolves itself to investigating the etiological factors, such as clearing up nasal pathology, reducing undue exposure, increasing the general resistance with tonics, cold baths, exercise and sunshine.

It has been my recent observation that zinc ionization has materially aided some few, but having only used this remedy for the past few months I can only throw this suggestion out with the hope that you give it a trial. Those patients whose sinuses are draining profusely seem to be most benefited, but the extension of this to other drugs may lead us to happy findings. I have used Dakin and Silver salts, but with a limited number of cases, hence I cannot report anything conclusive. In a paper now being prepared I will report these cases in detail.

It does occur to me that cod-liver oil is still a useful remedy and I prescribe it especially for children. Whether the fat vitamins or increased

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg May 19-20, 1925.

calories are responsible for the good I cannot say, but all of us have seen good results obtained and consider it useful. It would seem like quinine is losing its usefulness with the disappearing of malaria. For a while a remedy gives excellent results, then reports seem to conflict and finally it is discarded. Can it be that we accustom ourselves to this remedy or does the virulence of the organism vary? Or is there still another cause? It is an established fact that continued use of certain drugs reduce their efficiency and it may be that in the treatment of colds we have no exception.

Only a short while ago we were startled at results claimed for chlorine, but now our enthusiasm is waning and the best reports are those salvaged by the manufacturer. In my personal experience extending over a period of eight months I can only point to a small number of cases positively benefited by the use of chlorine, but believe that further experience will increase our knowledge so as to help us select the cases chlorine will aid. The only cases in my own practice that were really benefited were the ones treated very early. I would not want to give up the use of chlorine as yet and hope future use will bring out some valuable points not yet generally known.

If I have given you nothing new I will have at least reminded you of existing conditions as they appear to me so that future investigation will bring us a better understanding of this condition. With such a widespread prevalence and tremendous economic loss, colds and their treatment should be better understood.

#### DISCUSSION

*Dr. H. Marshal Taylor, Jacksonville:*

Etiology and treatment of the common cold is now receiving more attention perhaps than at any time in the history of medicine. At the last meetings of the American Laryngological, Rhinological and Otological Society and the Ear, Nose and Throat Section of the Southern Medical Association and the American Medical Association, symposiums on this subject were on the program. As yet there is a fertile soil for further investigation of this important subject, both as to the etiology and treatment. There is some question even with the tremendous development in medicine along bacteriologic and immunologic lines whether we really know more about common colds than did our forefathers.

Dr. Lischkoff has well said, "We can not lay

down one treatment for every case." It is important that the general practitioner as well as the rhinologist should in every case recognize the probability of an infection of the paranasal sinuses. The virtue of the chlorine treatment has yet to be proven. More physicians at this time seem to condemn it than recommend it. It seems that the manufacturers of the chlorine apparatus are its most ardent supporters. When you read of the violent attacks of asthma precipitated by its administration and some few deaths attributed to its use, it is easy to understand why the chlorine treatment has been condemned by the New York State Board of Health.

*Dr. B. W. Lowry, Tampa:*

I have always been very much interested in the subject of colds. Justly I think that all colds eventually become infectious. I don't think at first that there is a real infection, but after the cold has been in progress for twenty-four hours, I believe that the germs are there causing the symptoms. Therefore, with inflammation of the nasal passages there is congestion and an out-pour of secretion.

Now, the logical way to look at this is to reduce the stage of congestion to the stage of relaxation, and we have several methods of doing this: The first method is by free catharsis, that old-time remedy which I think still holds true. The second is by sweating the patient. This certainly reduces the congestion in the head. The third is by artificially shrinking the mucous membrane of the nasal passages by the use of adrenalin, cocain, etc. This merely dilates the nasal passage, it does not cure. It gives air and relieves the patient, but does not cure the case. Now, if you are going to cure the patient you have got to introduce some method of sterilizing the nasal mucosa. And in my cases the use of vaccines has been absolutely useless. I don't recall a single case where I can honestly say that I have cured a case of cold. I may have increased that patient's immunity to further colds, but I don't believe that I have ever cured a case by the use of vaccine, either autogenous or stock.

I have had the opportunity of using chlorine gas within the last year on one hundred selected patients, and I would like to report my results here. I use the Wallace inhalator. I have no confidence in the gassing chamber. I believe that you can insure the proper concentration over a period of one hour, and if you are to get

results you must have the same concentration at the end of sixty minutes that you had when you started. The only way you can do this is by the Wallace inhalator. The proper concentration should be point 105 of chlorine per leader of air. If this is taken over a period of one hour in cases of acute coryza, acute bronchitis, and acute laryngitis after the passages have been previously shrunk by adrenalin, you will get results. In my series of cases I can honestly say that between 40 and 45% of the acute coryzas were either cured of the symptoms or relieved within twelve hours after the first treatment. They came back on consecutive days, and the greater percentage were cured.

Now, I don't know whether this is due to the sterilizing action of chlorine on the germs, or whether it is the irritant action on the mucosa causing increased resistance, or whether it is due to the increased flow of serum which mechanically washes out the germs from the nasal passages, but I have gotten results with chlorine gas by using this particular method. I have used the air chamber, but not so much, for I have no confidence in anything other than the inhalator.

I do think that the use of mercurochrome and silver salts of course is good, but I don't believe that they compare with chlorine gas in treating acute head colds.

*Dr. M. A. Lischkoff, Pensacola (concluding):*

I have very little to add. But I do think that what Dr. Lowry has said about paranasal sinuses is worth considering. In every case of cold we do have a paranasal infection, but I do not know whether we are going to treat our paranasal sinuses in every case of cold.

I am sorry to disagree with Dr. Lowry, for his experience and mine has been so different in the use of chlorine. I have constructed a small chlorine chamber and carried out the chlorine inhalations as per instructions with apparently the correct dilution. I have not selected my cases, however, but in many cases have shrunk up the nasal mucosa, then used the suction pump, and then exposed them to chlorine; but I don't think that they were a bit more comfortable or got well any quicker than those that did not have the chlorine treatment.

## MODERN METHODS OF DIAGNOSIS AND TREATMENT OF URETERAL CALCULUS\*

EUGENE S. GILMER, M.D.,

Tampa, Fla.

The diagnosis and treatment of ureteral calculus has been discussed by medical men so long that the present consideration deals more with the advances which the specialist has been able to make. The advent of the cystoscope and the X-ray has revolutionized the diagnosis of stone and the treatment has been immeasurably improved. No branch of medicine or surgery has reached a higher point of diagnostic acumen than has urology with the recent refinements in instrumentation and diagnostic methods in the hands of trained men. Kretschmer divided the modern diagnosis and treatment of ureteral calculus into three more or less arbitrary periods. The first began when the use of roentgen rays was introduced as a diagnostic measure, when many stones were found and wrongly interpreted. The second began with the introduction of the shadowgraph catheter, and this was followed by the stereoscopic roentgenograms. To this I would add pyelography which is the most important aid in the diagnosis.

A complete physical and urological examination should be made in every case of suspected calculus, and the following questions should be considered:

First. Whether the trouble is in the ureter or elsewhere?

Second. If the condition is in the ureter, is it a calculus?

Third. If it is a calculus, how many are there, in what part of the ureter are they located, what are their size and shape, and are there stones on the opposite side?

Fourth. What is the condition of the kidney on the corresponding side as well as on the opposite side?

Fifth. What is the condition of the ureter containing the stone?

Sixth. What is the general condition of the patient?

A careful personal and family history should be taken, repeated examinations of the urine, X-ray study of the urinary tract, cystoscopy and

\*Read before the Fifty-second Annual Meeting of the Florida Medical Association, held at St. Petersburg May 19-20, 1925.



ureteral catheterization, and pyeloureterography.

The family history should include the occurrence of malignancy, tuberculosis or calculi. In the personal history, the former residence, social status, personal habits, present and past occupations, venereal history, past and present symptoms and signs, such as renal colic with the passage of stone, hematuria, pyuria, chills and fever, pains in the back, urinary symptoms, and unexplained or vague abdominal pain or tenderness are important. In the physical examination special attention should be paid to the blood count, blood chemistry, kidney function, and palpation of the abdomen for kidney, ureteral and abdominal enlargements and tenderness.

Examination of the urine may show blood, bacteria or urinary crystals, any or all of which may suggest the presence of a calculus. A few blood or pus cells may be of little importance, since they may be found in so many other conditions; but when taken in connection with other clinical data, may be valuable signs. When found, they at least suggest a careful urological study of the patient. If pus and bacteria are found in the known presence of stone, this finding may prove the deciding factor in the plan of treatment.

By X-ray examination we may be able to determine the presence or absence of stone; and if present, whether single or multiple, unilateral or bilateral, the exact location, size, shape and position. By repeated study we may also determine whether the stone is impacted or whether it is making progress along the ureter and will probably be expelled spontaneously.

It would seem that, with modern methods of X-ray diagnosis, few stones would pass undetected with an expert roentgenologist, who is given sufficient opportunity for repeated study. However, the fact remains that quite a few stones are not recognized by X-ray examination. Braasch and Moore state that it is doubtful if an accurate diagnosis of ureteral calculus can be made from a roentgenographic examination alone.

Rowland reports that in twenty cases he had removed stones from the ureter where the radiologic reports were negative. He does not attribute this to poor radiography, but thinks it is due to small or translucent stones or to the obesity of the patient. Failure to recognize stone may also be due to its relation to bone. Cabot and Dodd suggested that, in cases where

the suspected calculus lies over the sacroiliac joint, by taking a radiogram with the tube placed over the umbilicus and focused obliquely down into the pelvis, we may detect a calculus obscured by this bone. Cabot found that 6% of 127 cases were persistently negative to X-ray, but he believes that, as a rule the roentgen rays in competent hands at the time he made his report failed to detect stone in 10 to 15% of the cases. Geraghty and Hinman found that X-ray failed to show the presence of stone in 15% of their cases, and in Kretschmer's series X-ray failed to show the stone in a little less than 11%.

By cystoscopy and ureteral catheterization, we may study the general condition of the bladder and the ureteral orifices. If a stone is situated in the lower part of the ureter near the bladder, there may be either a discoloration of the vesical mucosa around the orifice, bulging of the bladder wall over the stone, œdema of the ureteral orifice, and sometimes the calculus may be seen protruding from the orifice. Some authorities state that a wide open, paralyzed sphincter of the orifice is diagnostic of stone. Ureteral catheterization will allow study of the kidney on the corresponding side as well as on the opposite side and an index may be obtained as to their condition. We may determine whether there is an obstruction in the ureter and its exact location. Catheterized specimens of urine may be obtained from each kidney and examined. The wax-tipped catheter may be passed and examined for scratch marks in doubtful cases. Lastly, opaque solutions may be injected through the catheter, pyeloureterograms may be made and a clear outline of the ureter and calyces obtained; and a calculus that has failed to show in previous radiograms may be coated over by the opaque fluid and will show readily by radiography. It is better in this case to allow a few hours to lapse between the time of injection of the opaque solution and the radiography to give the fluid time to drain off and leave the calculus coated. Negative shadows may be demonstrated by this means that would not show any other way.

Several cases have been reported of palpation of ureteral calculi by vaginal and rectal examination, but this is seldom possible and is of little value in comparison to other means of diagnosis. Exploratory operations should never be performed as a diagnostic measure.

Ureteral calculus must be differentiated clinically from ureteral stricture and ureteral kinks. By radiography, ureteral calculi may be differentiated from prostatic calculi, bladder concretions, atheromatous patches on the arterial wall, exostoses, foreign bodies and concretions in the intestines, surface moles, calcified lymph glands, gall stones and phleboliths; all of these can practically always be differentiated by use of the cystoscope, shadowgraph catheter, roentgenography and stereoscopy.

Treatment of ureteral calculus consists of expectant, conservative and radical. We can offer no rational or scientific prophylactic measures until we can definitely determine the etiology of urinary stone.

**Expectant treatment:** Various and sundry drugs and mineral waters have been recommended for the disintegration of stone, but none has proved of any real value. The only report in the literature that I have been able to find is by Crowell, who succeeded in accomplishing the disintegrating of a cystine calculus by a low protein diet, alkalization of the urine and lavage of mercurochrome 220. Israel recommends the daily administration for one week of two quarts of mineral water and three ounces of glycerine.

**Conservative treatment:** There seems to be a divergence of opinion regarding the operative treatment of this condition. European surgeons seem more inclined to open operation, while the tendency of America is toward conservatism.

Most authorities agree that a stone less than one cm. in diameter should be expected to pass spontaneously, while others claim that in the absence of infection and other unfavorable circumstances much larger ones should be given the opportunity to pass. I recently observed a case in which the stone measured one and one-half cm. in diameter and traveled from the kidney pelvis into the bladder with scarcely any discomfort to the patient and no notable damage. The procedures in a given case must, of course, be left to the skill and judgment of the attending surgeon. Braasch thinks that the majority of stones will probably pass within two or three months following the first symptoms, and that in the absence of complications we should wait for from three to six months. Judd found that, in 400 cases, 12% passed unaided and in 16 cases Kahle found that 33% passed spontaneously.

It is unsafe to leave a ureteral calculus in-

definitely. If it is not making sufficient progress in its descent toward the bladder; if there is evidence of infection, urinary obstruction, or interference with the kidney function; if there is a calculus in the opposite ureter, then some form of active interference must be instituted to either assist the stone in passing or to remove it. It is evident that ureteral calculi should be treated more systematically and promptly than renal calculi. I recently found it necessary to remove a very small migratory calculus that was causing intermittent obstruction and serious damage to an infected kidney.

The question arises whether our procedure shall consist of cystoscopic and ureteral manipulations as the conservative treatment or open operation for the removal of the stone. If the stone is not too large and not in the upper ureter, if it is not a case of multiple or bilateral calculi, if it is not impacted so as to prevent the passage of catheter or bougie, and if instrumentation is tolerated, we should adopt the conservative measures, unless contra-indications arise, until we feel sure our efforts by this method will be unsuccessful. Its advantages are obvious. Aside from relieving the added inconvenience necessary to open operation it gives the patient immediate relief by draining the kidney and relieving back pressure, thereby preserving its integrity, and assists the stone in its passage along the ureter by either changing its position or dilating the ureter so as to give it easier passage. Many authorities agree that we should not wait for ureteral stones to pass spontaneously, but that intraureteral manipulation should be begun early. Buerger believes that it is advisable in almost every case, after the stone has found lodgment, and in every case of obstruction, unless the stone is passed within twenty-four to seventy-two hours. He has also observed that the greater the distance between the stone and the kidney the less damage there is likely to be to the kidney.

Intraureteral manipulations may consist of simple ureteral catheterization in which one or more catheters are introduced past the calculus and left for varying periods of time. This is repeated at intervals until the stone passes or the ureter is dilated to 12 or 14 F. If two or more catheters are introduced they should be crossed within the ureter and removed simultaneously, when they may drag the stone out with them, or at least for some distance along the



ureter. A recent authority recommends the passage of large, tunneled metal bougies. Some surgeons think that oil or glycerine injected through the catheter assist in the expulsion of stone. Others use papaverine or other similar agent to relieve ureteral spasm. Dilation is sometimes accomplished by means of the Garceau catheter or the Bransford Lewis metal dilator. If the stone is in the intramural portion of the ureter, fulguration is sometimes more effective. If it can be seen protruding from the orifice it may be grasped by forceps and withdrawn. In cases of intramural impaction, incision of the upper lip of the orifice may allow expulsion of the calculus.

Crowell and Thompson believe that nearly all recently impacted ureteral calculi can be removed by intraureteral manipulation and report seventy-eight consecutive cases, seventy-six of which were removed by this means. The writer has been successful in removing the ureteral calculus by this means in ten consecutive cases in the past few months, one of which was an impacted calculus which required three efforts to introduce a bougie past the obstruction.

Radical treatment: Calculi that do not pass spontaneously, or after repeated unsuccessful attempts at removal by intraureteral manipulations, should be removed before too much damage is done to the kidney. Encysted calculi or those too large to pass require operative removal. If there are evidences of urinary suppression, of infection of the kidney back of the stone, or repeated "colic"; if there is evidence of serious impairment of renal function; if there is a hydronephrosis not sufficiently relieved by ureteral catheterization, open operation should be performed unless cystoscopic manipulations are immediately successful. Cases of intolerance to cystoscopic manipulations, or where these manipulations tend to light up an old infection, should be operated on. We should not temporize in cases of bilateral calculi and, in these cases, the one giving the greater amount of trouble should be removed first. If there is a calculus in the kidney on one side and in the ureter on the other, the one in the ureter should be removed first. In cases of calculous anuria, nephrostomy should be performed first and the calculus removed later.

The type of operation to be employed depends upon its location in the ureter. If it lies in the upper third, the incision should be the same as

for exposure of the kidney; if in the middle or lower third, an exaggerated McBurney or a Gibson incision will give proper exposure. If the calculus is movable, a longitudinal incision should be made in the ureter just above its location and the stone displaced upwards since there is danger of opening through ulcerated mucous membrane in making the incision over the stone. Unless the incision in the ureter is of considerable length, it is probably better not to suture the ureter, but a small rubber tissue drain should be left down to the ureteral incision as long as there is any ureteral drainage.

In closing, let me warn against any operative procedure without an immediate X-ray examination, as much time may be lost trying to find a calculus that has changed its position since it was last located by the X-ray.

#### DISCUSSION

*Dr. Rob't B. McIver, Jacksonville:*

The question of stone in the ureter is of more importance than we are apt to assign to it.

A decade ago many general surgeons of considerable ability operated for stone upon making the diagnosis; this was considered good practice in many localities as recently as five years ago. At present it is very definitely established that only a small percentage of ureteral calculi require an open operation. In our experience 90% of the calculi that do not pass spontaneously can be assisted into the bladder by intraureteral manipulation.

Dr. Gilmer has been able to cover the subject in considerable detail in fifteen minutes. I have nothing to add to his paper, but will demonstrate a series of lantern slides which illustrate some of the many problems presented by ureteral calculi.

(Slides)

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#### THE PHYSICIAN AND THE HEALTH OFFICER

F. A. BRINK, M.D.,

*Director, Bureau of Communicable Diseases,  
State Board of Health.*

Practically all who undertake the study of medicine, graduate from a reputable college and secure a license to practice the healing art, are of good moral character, interested in the welfare of the human race at large and have more than the average amount of interest and pride in the community where they live and work. It



is rare, indeed, to find a practicing physician who would not devote his best effort to the prevention of unnecessary sickness. Although nearly all doctors must depend on the income from their practice for a livelihood, it is only under exceptional circumstances that one becomes mercenary or resorts to questionable methods to increase his income. The crooked doctor is quickly recognized by other members of the profession, excluded from medical societies and soon known by all as a charlatan. He has both the contempt and pity of his confreres and he enjoys neither prosperity or the friendship of his associates. All this is preliminary to a word of recognition and appreciation from a health official to the ethical practitioner who, when approached in the right spirit and given the consideration he merits, never fails to give his moral support, time, skill and even financial support to any scheme that will improve the health of the people he serves.

There is no other profession or class of people who will, for the benefit of their community, put forth effort that might be expected to reduce their income. But, strangely enough, those practitioners who are most ready to work for the promotion of the public health are the most successful financially. Whether this is due to the ministrations of a kind Providence or merely the natural sequence of cause and effort, may be left to conjecture, but it may be noted in passing that the family or community that enjoys the best health is also the most prosperous and best able to meet its financial obligations; conversely, the sickly family or community has little but poverty to share with the doctor.

Frankly, it must be admitted that, aside from a feeling of gratitude to the profession, the writing of this article is prompted by a wish to foster and encourage that spirit of community helpfulness on the part of the physician which, after all, benefits him and his family as much as anyone.

Public health workers in the Middle West tell of a fear that is growing among the doctors that state medicine may deprive them of a livelihood. Ill-founded as this fear may seem, it must be recognized and allayed if the best interests of the people and the profession are to be conserved. To the writer there seems little danger that the practitioner will be replaced by men employed by the state, and the doctors of Florida have expressed no anxiety about it. Certainly the state is not likely to offer the public anything in the way of disease prevention or cure that is already

provided by local physicians. There will always be enough for the official health worker to do without invading the province of the practicing physician. The health worker will have to keep pointing out to the public the physical defects of children and advise correction by the family physician or specialist, he must keep insisting on the prevention and cure of hookworm disease, malaria, diphtheria, etc., there will be communicable disease patients to isolate, group examinations to make, immunization and laboratory tests that can best be done by full time employees of the state, but the time will never come when the community can dispense with such individual services as the family doctor alone can render, and never will the family doctor fail to serve the community in time of need as he has always done.

The doctor of medicine who devotes all his time to public health work and receives a stipulated salary is still a doctor of medicine. He should extend and receive the same professional courtesies that are recognized by men in practice. He cannot, however, do all the health work that must be done. One of his chief activities is to stimulate the interest of the people in doing health work for themselves and instructing them in the manner of doing it. In this it is essential that he have the backing of the local doctors, for people will heed advice coming from both better than if it came from either alone. It is not true, as sometimes stated, that since we have paid health workers there is no longer need for the volunteer services of the practicing physician. The need is almost as great as ever and there is every reason to believe that the practicing physician will continue nobly to render those services.

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## THE LABORATORY AS AN AID IN DIAGNOSIS\*

WALTER C. JONES, JR., M.D.,  
Miami.

It shall not be the purpose of this paper to deal with the various techniques necessary to obtain the results sought, nor attempt in every case to explain the underlying principle, since these are so well undertaken in the various laboratory manuals of the current medical press. In as large a scope as time will permit, the reports of

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the laboratory will be discussed and conclusions try to be reached which will be of value to the general practitioner in his every-day rounds. In this connection, however, it will not be possible to discuss all the various clinical findings of each case, and conclusions stated will try to be those of the average cases and not the unusual ones.

In consideration of the *sputum*, much is of value to the clinician, but probably nothing more important than examination for the tubercle bacillus. A negative report does not necessarily mean that the patient is free from tuberculosis; for tubercle bacilli do not occur in the sputum until a secondary infection has occurred, and the resulting small cavity formation. Then, too, when the case is far enough advanced to have the bacilli present, if one examination fails to show them, continue daily examinations for at least three days and preferably using the 24-hour amount with the concentration technique. In this connection let it be clearly understood that you are doing your patients a criminal injustice if you wait until you find the bacilli to notify them that they have tuberculosis. In its incipency by your clinical history and physical findings, together with your personal observation of the case, forewarn your patient of approaching danger and by all means don't wait for a positive report from the sputum. In an advanced case, apparently tubercular but with a negative sputum, the "court of last appeals" is the inoculation into the guinea pig—this is absolutely a reliable test if performed properly. The presence of *elastic fibers* in sputum means that lung tissue is being destroyed, and the most common causes of such destruction are tuberculosis and gangrene. *Curschman's Spirals* and *Charcot-Leyden Crystals* are most frequently seen in bronchial asthma.

In interpreting the sputum report, ask first is it negative or positive? If positive, then for tuberculosis the diagnosis is made; if negative but elastic fibers are present, it is suspicious, and request another examination and concentration technique; if still negative, continue for at least three successive examinations before abandoning a suspicious case. In all cases rely first upon the findings of the case and a common-sense clinical judgment, and then if the laboratory report helps in diagnosing the case, so much the better; but don't let the laboratory report be paramount. It has its place and is of inestimable value so often, yet it becomes

mighty easy to rely on it and forget that most valuable of the practitioner's implements, clinical judgment.

A routine examination of the *urine* is a good habit to form and will save many a slip along the arduous pathway. The general medicine man cares not what may be the interesting features of a specimen so far as they concern the laboratory man, but his main thought in testing the urine is to find out if his patient possibly has some disease of the kidneys or genito-urinary tract.

The presence of sugar does not mean diabetes mellitus in every case—lactose in a nursing or pregnant woman may be the cause, or emotional strains, or excessive carbohydrate ingestion. Then, too, the absence of sugar in a single specimen does not rule out diabetes; some cases only excrete sugar at certain hours of the day and some, with a markedly increased blood sugar, may show no sugar in the urine. *These points* must be borne in mind when translating the urinary report of a suspicious diabetic—is the quantity increased; is the specific gravity increased, then what is the percentage of blood sugar?

Albumen present—what does that mean? No greater mistake can be made than to regard all cases of albuminuria as indicating kidney disease. Excessive muscular exertion, excessive eating or drinking, prolonged cold baths, and posture may be the cause of a transient albuminuria which will clear up when the cause is removed. Abnormally it may be present in anemia, purpura, and scurvy in small amounts because it is more diffusible in such cases; also in anemia or congestion of the kidneys themselves; and especially in organic diseases of the kidneys as the various types of nephritis, tuberculosis, tumors, and cloudy swelling due to toxin and drugs. It is in large quantities in all cases of nephritis except the chronic interstitial type where it is less marked.

*Casts* may be present in large numbers due to a temporary irritation or congestion — within themselves they do not imply organic disease of the kidney, but simply indicate the condition of the tubules in which they were formed. Hyalin casts are the least significant and in small numbers they follow ether anaesthesia, fever, exercise, congestion, and kidney irritation. Granular casts, fine and coarse, indicate that the process is a bit further advanced and that organic changes



are occurring in the tubules; the same is true of fatty casts, indicating that partial or complete disintegration of the renal epithelium is occurring. Waxy casts occur in advanced cases of nephritis, most commonly in amyloid disease of the kidney. There are other types and variations of cast, depending upon the degree of disease and combinations of types.

*Pus corpuscles* occur in very small numbers, normally. Their increase may be due to infection along any portion of the genito-urinary tract or within the kidney and its pelvis. With clinical symptoms of a pyelitis—one of the most common causes of temperature in children—failure to find many pus corpuscles at one examination does not rule out pyelitis; for the kidney flushes itself irregularly in some cases and one specimen may be clear and the next cloudy with pus.

*Red corpuscles*, too, may come from any portion of the genito-urinary tract—if bloody urine, use the 3-glass test and it may be possible to determine the site of origin. If the blood is chiefly in the first glass, it is probably urethral; if in the last, it is probably in the bladder. If the blood is uniformly mixed in all 3 glasses, it probably comes from the kidneys or ureter. Blood from the kidney is due to severe hyperemia, renal tuberculosis, malignancies, hemorrhagic disease, and renal calculi (in small amounts with pus corpuscles and crystals).

*Indican* is increased in intestinal trouble, hypochlorhydria, or decrease of flow of bile. It commonly bespeaks some intestinal putrefaction and is most marked in intestinal obstruction.

*Specific gravity*—average is 1.017 to 1.020, but it is low in chronic nephritis, diabetes insipidus, and nervous diseases, being high in acute nephritis and diabetes mellitus. A sudden fall of the specific gravity in any nephritic case, without a corresponding increase in the quantity of urine excreted, forebodes uremia. A very valuable simple test of renal efficiency is a test for fixation of specific gravity—have specimens collected every 2 hours during the day and put in separate containers, likewise collect as a whole the night specimen. Take specific gravity of each and measure the quantity excreted. Normally the urine will vary 12 or more points during the 24 hours. If there is a variation of less than 9 points and the quantity excreted at night exceeds that of the day, then you most likely are dealing with a case of chronic nephritis. Cabot

is very emphatic in proclaiming this one of the most reliable tests for chronic nephritis—however, in reaching such a conclusion the clinical picture must not be lost sight of.

The phenolsulphonephthalein functional test is also of valuable assistance in arriving at a conclusion as to renal efficiency. Normally the first trace appears in 5-11 minutes, and during the first hour 40-60% is excreted and at the end of the second hour 60-85% of the quantity injected has been excreted. Variations of these amounts form the basis of conclusions as to the involvement of the functional capacity of the kidneys proper.

The presence of acetone bodies—diacetic acid, acetone, and Beta-oxybutyric acid—is due to abnormal katabolism. Acetone is sometimes present in fevers, nervous diseases, gastro-intestinal disturbances, lack of carbohydrates, and often in pernicious vomiting of pregnancy and eclampsia. In diabetes mellitus the presence of any is an indication of its severity. They can be diminished by the giving of liberal carbohydrates. The mildest form is acetone, then diacetic acid, and worst is Beta-oxybutyric acid.

In studying the *blood*, probably 90% of the information obtainable can be obtained by an estimation of the hemoglobin and a study of a stained smear. The normal quantity of *hemoglobin* is 14 grams per 100 c.c. of blood and read as 100% upon such a basis. It is *increased* in change from a lower to a higher altitude, heart disease with cyanosis, concentration of blood as in severe diarrhea of cholera and in "idiopathic polycythemia." There is a *decrease* in the anemias, malignancy, hemorrhages, hookworms, chlorosis and leukemias. The *color index* is obtained by dividing the percentage of hemoglobin by the percentage of red blood cells. It is normally 0.8-0.9, but is usually markedly decreased in chlorosis and the secondary anemias, while there is quite an increase in pernicious anemia—1.0 or more.

The *erythrocytes* normally are 4½ to 5½ million and show an increase in change from a lower to a higher altitude and markedly so in "idiopathic polycythemia." There is varied decrease in the anemias, and chlorosis, but the most marked is found in pernicious anemia, where counts below 1 million are not uncommon. In this latter condition change in size, shape, and staining qualities is quite marked. Here also are



found nucleated red cells, but especially the megaloblasts.

The *leukocytes* vary normally from 5 to 10 thousand, being low in the poorly nourished, anemias, and aged; while they are high in the new-born, children, after the digestion of a meal, and after cold baths. A pathologic decrease of the leukocytes, or a *leukopenia* is seen in pernicious anemia, tuberculosis, typhoid fever, typhus fever, malaria, measles, mumps, dengue, influenza and scarlet fever. An abnormal increase or a *leukocytosis* is found in all inflammatory and suppurative diseases unless very slight or well walled off. The increase depends upon the severity of the infection and the resistance offered by the individual.

It has been said the percentage of polymorphonuclear leucocytes indicates the severity of the infection and that the total count is a guide as to the resistance offered. A gradually increasing leukocytosis indicates a spreading process, a percentage of polymorphonuclear-leukocytes of over 85% points towards pus formation. There is a moderate leukocytosis in malignant conditions, following hemorrhages, toxic conditions, and following the administration of tonics and stomachics. A *lymphocytic leukocytosis* is seen in pertussis, where the number may reach 18,000 with a marked predominance of small lymphocytes — rickets, scurvy, and hereditary syphilis likewise show a moderate lymphocytic leukocytosis. There is a relative increase in the *large mononuclear leukocytes and transitionals* (or "endothelial leukocytes" as they are sometimes classed) in typhoid fever, malaria, and early Hodgkins disease. An *eosinophilic-leukocytosis* (relative) occurs in cases of intestinal parasites, bronchial asthma, scarlet fever, skin diseases, and following tuberculin reactions and anaphylaxis.

*Myelocytes* in considerable numbers are diagnostic of myelogenous leukemia. In the anemia of malignant disease, when found, they suggest bone-marrow metastasis. *Myeloblasts* are the parent cells of the myelocytes and are found in large numbers in acute myelogenous leukemia and the late stages of chronic myelogenous leukemia—hence are of prognostic value.

In searching for malarial parasites the best time to take the blood is a few hours before the chill, when the parasites are well grown and before they rupture into the blood stream. Quinine causes the parasites to disappear from the peripheral blood and few or none may be found

after its administration. When it is impossible to find the parasites, the presence of pigment granules within the leukocytes—especially the large mononuclears—may be taken as presumptive evidence of malaria. These are most numerous after a paroxysm. It is claimed a hypodermic injection of adrenalin Hydrochlorid (1:1000 Mx) will cause the parasite to appear in the peripheral blood.

In studying *gastric contents* the test meal and time of removal has much to do with the results. From various experimentations it has been proven that the fractional removal of 5 c.c. every 15 minutes, and test of same separately, gives a far more accurate estimate of the gastric function. In some cases the acidity may rise rapidly and reach its maximum in 30 minutes and return to normal by the end of the one-hour period, and in other cases the maximum acidity may not be reached until after the one-hour period. If only the one-hour specimen is studied, clearly it can be seen that the actual condition of the stomach has not been found. With the Rehfuess fractional method in cases of *gastric ulcer*, the ascent of the acid is rapid and may reach its maximum before the hour or a little after. The high point of free acidity may be between 60 and 70 and the total acidity between 100 and 110. There is then a gradual decline as the stomach empties itself. In *duodenal ulcers* the ascent of the acid curve is gradual and proceeds to reach its maximum height when the stomach is emptying itself. In *gastric carcinoma* with obstruction, the free acid is either entirely absent or rises to a point between 10 and 15 after one hour; on the other hand, the total acidity may be normal or above normal. Reflex irritation due to gall-stones, appendicitis, etc., may influence the gastric curve markedly and give results simulating ulcer.

In the *feces* traces of occult blood are found in practically every case of gastric cancer and ulcer, also in malignancy of the intestines, and in presence of certain intestinal parasites. After a very heavy meat diet occasionally a positive test may be obtained. The presence of certain parasites, their ova, or segments is absolutely diagnostic of the respective conditions. In having a search made for the *Endameba Hystolytica* it is absolutely necessary that the specimen be fresh and kept warm until and during the examination.

In all suspicious throats a smear and culture should be made for the diphtheria bacillus. To

neglect such may mean an inexcusable mistake; for in diseases where positive assertions can be made and specific treatment given, to fail to avail oneself of the opportunities approaches criminal negligence. Cultures of various infections may assist greatly in diagnosis and treatment. A negative smear for gonococci in the male or female, but especially the latter, does not exclude the presence of the disease deep-seated. A positive smear in such cases is without a question diagnostic of the venereal condition.

In all suspicious lesions of the genitals, a dark-field examination for the *Spirocheta Pallida* is justifiable, and if the spirocheta are found, treatment should be instituted at once and not wait for a positive Wassermann, which may not appear before the second or third week and often as late as three months; by such delay the parasites multiply and become diffused throughout the lymph and blood paths, thus rendering cure less rapid and less sure. The ideal time for treatment of syphilis, therefore, is in the primary stage with a negative Wassermann. The Wassermann reaction as a rule becomes rapidly and strongly positive as the general manifestations of the disease develop; in late and especially in latent syphilis the reaction again grows weaker and in cases negative. Again it is to be emphasized that the case as a whole must be studied and not too much dependence placed upon the laboratory report except as it backs up the clinical findings. A negative blood Wassermann is no evidence of the absence of neurosyphilis; an examination of the spinal fluid, not only for the Wassermann reaction but as to cell count, protein estimation and colloidal gold test is extremely important in suspicious cases.

In the *Widal reaction* for typhoid fever, a positive result is of no value if the patient has received anti-typhoid vaccination within several years previously. The positive result simply means that the patient's body has a sufficient antibodies to cause an agglutination of the typhoid bacilli when brought into contact with the same. In a true case of typhoid fever with no previous vaccination, a positive Widal is rarely obtained before 10-14 days. The diagnosis of typhoid fever in the first week or ten days depends upon a positive culture of the typhoid bacilli from the blood.

The *Schick test* shows whether or not the patient has sufficient antitoxin to overcome the diphtheria toxins. If a reaction occurs, it means

that the patient is susceptible to diphtheria, and would likely contract the disease if exposed to same; if there is no reaction, the patient has an immunity to the disease and for all purposes is safe against contracting same. Practically this test is being used now in many public schools, and those showing positive reactions are given the toxin-antitoxin immunizing treatment.

The purpose of this paper will have been fulfilled if in any manner the interpretation of laboratory reports has been made clearer and an estimate placed upon those of most practical value to the general practitioner.

The past decade has been one of the laboratory and its associates and during this time, frequently, too much stress has been laid upon the value of the same as diagnostic and prognostic aid. At present the pendulum is on the turn and starting on its backward swing; however, let the laboratory continue in its good work, not as the supreme criterion and monarch, but as a valuable adjunct to that most judicious and helpful ruler, clinical observation and common-sense judgment.

#### DISCUSSION

*Dr. D. T. Babcock, Miami:*

I am sure Dr. Jones does not leave me much to say—just a few points worth mentioning.

In cases of latent syphilis, we might say, the positive Wassermann test is probably one of the most valuable. Another thing that has come to our attention recently in South Florida, is the leukopenia that we see in dengue. Recently we had several cases which were very mild, and it was only after blood count was done that we were able to clear it up. You always get a leukopenia in dengue.

Another thing that might be mentioned in the important laboratory tests—the test for amoeba. It is very important in cases of anemia and cases where there is a destruction of red blood cells. There is usually urolilin present in the urine. Another thing seen in gross examination of urine sometimes, especially if the number of amoeba is large, and that is a cloud or sediment which does not mean anything grossly, which is generally phosphates because the urine is so heavy with calcium salts.

When doing this test the tube should be heated up to about body temperature before inserting, and if you will also try to get some of the mucous membrane as well as the feces, you can generally locate the amoeba, as they are in the colon itself



and it is very hard to get them unless you do get some of the mucous membrane.

I am sure the main point in this paper was that we should use the laboratory as an aid to diagnosis and not rely too much on it.

*Dr. B. L. Arms, Jacksonville:*

I was very much pleased to hear Dr. Jones' paper, and I heartily agree with him in what he gave as the keynote of his paper—that the laboratory was to assist the physician and not to take the place of the clinical diagnosis. A negative laboratory report should certainly be weighed, and only as much value given to it as any other negative report. If a laboratory report does not agree with the clinical, the chances are that your clinical is right, and that there is something wrong with the laboratory. I don't mean that it is the fault of the technique, or anything of the kind, but something wrong with the specimen the way it was taken or handled somewhere in passage between the patient and the laboratory.

I was very glad to hear this paper and have tried to emphasize that side of it, that the laboratory was to help and not to make the diagnosis.

*Dr. W. W. Kirk, Jacksonville:*

It is not by way of commenting on the particular technique or the value of the tests in Dr. Jones' paper that I wish to speak, but I wish to more or less sound a keynote on a very vital issue of laboratory work.

We all know that, particularly in the South, the charity or semi-charity patient has more extensive laboratory work done for him, and more routine work done for him and more special work done for him than any other type of patient.

In other words, the question I am bringing up in the last moments of this meeting is the vital question of how much he is going to have to pay for adequate laboratory study, which is a very vital issue with a number of people. I think that any patient who is sick enough to be in bed or in the hospital should have a reasonable amount of laboratory work done. If done along the proper lines it is a very valuable thing. In certain cases leave out certain special tests on one man which would be done for another patient, and in that way a great deal more will be accomplished for the patient, both as to health and as to his ultimate discharge from the hospital and speedy return to work.

It is very common knowledge that to have any

extensive laboratory work done will mean fifteen to thirty or forty dollars, which a great number of people cannot afford to pay.

I think that the sooner the general practitioner, the internist and any man who has to have laboratory work done for his patients, will come to the conclusion that it might be the privilege of the laboratory man to examine the history and notes on the case, and, if necessary, question the patient, not with the idea of taking up the therapy of the case, but with the idea of eliminating useless examinations for that particular case, the sooner a field for a consulting pathologist could be opened that would be of value all the way around.

### STRICTURE OF ESOPHAGUS DUE TO LYE BURNS\*

JOSEPH HALTON, M.D.,  
Sarasota, Florida.

Lye as purchased in the open market is composed of ninety-four per cent sodium hydroxide, a most destructive corrosive. The swallowing of a thimbleful is sufficient to cause a stricture of the esophagus.

I submit for your inspection two cans of lye purchased in the open market to show you how the dangers of this mixture are covered up by the insignificant display of the word "Poison" upon the label. It certainly does seem that the commercial interests should be compelled to make a more blatant display of the word "Poison" on these cans.

The cause of stricture of this sort lies primarily in gross carelessness. Lye in solution is left within easy reach of small children, whose childish inquisitiveness results in the drinking thereof.

The swallowing of lye is immediately followed by excessive flow of saliva, wrenching and vomiting of the child, plus great excitement in the community.

The esophagus is a senseless kind of organ. Deficient in nerves and liable to throw spasmodic fits. This illustrates another one of nature's physiologic actions in that it protects the stomach most, the victim vomiting rather promptly, thus flushing the esophagus with antidote, acid secretion. The acid secretion of the stomach

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\*Read before the Fifty-third Annual Meeting of the Florida Medical Association, held at St. Petersburg, May 19-20, 1925.



protecting this organ from the corrosive action of caustic alkali.

Immediate treatment: Give acid to neutralize the corrosive action of the alkali. One of the handiest things in all homes is a solution of vinegar. There is no marked difference for some time in swallowing, after the primary burns have healed. The stricture does not form immediately and may take several weeks. But there is a slow progressive increase, until suddenly, several weeks afterwards, almost complete esophageal stenosis occurs.

#### SUMMARY.

History of swallowing lye:

Deysphagia, regurgitation, swallowing and later sluffing of the mucous membrane, and formation of cicatricial tissue; which contracts and results in various degrees of stenosis; loss of weight; esophagitis due to stagnation and fermentation of food in the esophagus.

Haste in dilating stricture of esophagus after injection of this corrosive fluid is to be deprecated from fear of perforation.

#### CASE HISTORY.

The two cases that I have to show you today are interesting from the standpoint that one refused operation and died, and the other case accepted operation and is now living.

*First Case.*—The child was aged three years and I saw her in consultation immediately after the burning. The child was crying and an excessive flow of saliva was pouring from its mouth. Examination did not show any blanching or discoloration inside the mouth. Six months afterwards the child was brought to the hospital and I found the following conditions on X-ray examination.

*Second Case.*—Was a colored child two years old, who drank lye and six months later was brought to the hospital. Her inability to swallow was pronounced and she was greatly emaciated and dehydrated.

The pre-operative X-ray picture shows:

*Operation.*—Under ether the abdomen was opened through the left rectus muscle. The stomach was drawn into the wound and four rows of purse string sutures inserted; stomach incised, tube introduced and the stomach wall invaginated between the purse string sutures. The X-ray picture shows tube in place.

*Treatment.*—Early treatment of these cases must be with water as the children are tremend-

ously dehydrated. A person can go forty days without food but cannot well survive three days without water.

First two days two ounces of water every thirty minutes to which was added sodium bicarbonate until child's urine became alkaline, thereby offsetting starvation acidosis. Urinalysis showed 100 per cent total acidity.

First week, two ounces of milk every two hours; second week, three ounces of milk every four hours; orange juice twice per day.

*Post-operative.*—After three weeks' post-operative I began dilating the esophagus with catheters and bougies. (X-ray picture post-operative.)

While this treatment is not approved by the men who have had more experience in these cases than I, yet owing to the sociological condition, for instance lack of funds, one is compelled oftentimes to violate the rules laid down by our well-equipped surgical centers.

Therefore to any criticism made along the line of technique and conduct of these cases, must be answered in the words appearing upon the old sign boards in the western dance hall of '49, "Don't shoot the fiddler, he's doing his best."

#### DISCUSSION

*Dr. Walters, Ocala:*

About two months ago a little girl was brought to me with a history of having swallowed lye approximately ten months previously. The girl was four years old. She was not emaciated and with the history of the duration of time it was really surprising the well-nourished condition of the child, especially after I had found a stricture which was so small that the only thing I was able to pass was an ordinary Bangs bougie. Since that time the little girl has been able to swallow fairly well, but I have never been able to get anything by this point (demonstrating) larger than an ordinary bougie. I have tried to pass a silk thread on that child hoping later to be able to use a Sippy dilator with the thread as a guide. However, I would be afraid to pass anything other than something so flexible that there would be no chance of perforating the esophagus. If this cannot be accomplished, I see no other alternative but a gastrostomy.

Unfortunately, I have been unable to see this case for three weeks, but after she had had the bougie passed once or twice her father told me that she was able to swallow, and I am pleased

that she is able to get by with enough food to maintain nutrition. You will notice quite a bit of dilatation above the stricture at this time (demonstrating).

*Dr. Knauer, Jacksonville:*

I think the subject of lye stricture is one of importance and should be presented yearly before the medical association. There is one thing I wish to emphasize and that is the treatment: Begin early on these cases if you are going to get any results. I have begun dilatation of these

lye cases as early as the tenth or twelfth day with a great deal of success, and had very little remaining stricture. If the esophagoscopists could get these cases within the first three weeks and dilate under direct light, the majority of them would not have to have a gastrostomy performed. In the beginning, I usually dilate every day or every other day until the stricture will admit soft food, and then gradually taper down to about once or twice a week, and then once or twice a month until the patient is able to go without further dilatations.

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### THE PROPOSED REVISION OF THE CONSTITUTION AND BY-LAWS OF THE FLORIDA MEDICAL ASSOCIATION

A special committee consisting of three members, namely: Dr. John S. Helms of Tampa, Chairman; Dr. R. H. McGinnis of Jacksonville, and Dr. H. J. Walters of Ocala, was appointed by the Chair during the general meeting of the Association held on the 19th of May, 1925, at St. Petersburg, for the purpose of considering the feasibility of revising the Constitution and By-laws of the Florida Medical Association. The following day this committee submitted the following proposed revision of the Constitution and By-laws. This was duly read and received by the general meeting of the Association.

Article 10 of the present Constitution provides as follows: "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken."

Chapter 13 of the By-laws provides as follows: "These By-laws may be amended at any annual session by a majority vote of all the delegates present at that session, after the amendment has laid upon the table for one day."

It is requested that each of the integral county medical societies give due consideration to the suggested revision of the Constitution and By-laws and instruct their delegates as to their desire in accepting or rejecting the proposed changes.

### CONSTITUTION

#### ARTICLE I.

*Name.*—The name and title of the corporation shall be The Florida State Medical Association.

#### ARTICLE II.

*Purpose.*—The purposes of this Association are to promote the science and art of medicine, and the protection of public health. More especially the purpose of this organization shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar organizations in other states to form the American Medical Association. Its purposes shall be to extend medical knowledge; to elevate the standard of medical education; to encourage enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to safeguard and foster their material interests; and to enlighten and direct public opinion to the great problems of state medicine; so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

#### ARTICLE III.

Section 1. *Component Societies.*—Component societies shall be those county medical societies which hold charters from this Association.

Sec. 2. The terms, county medical society and component county medical society shall be deemed to include all county medical societies now in affiliation with this Association, or which

may hereafter be organized and chartered by the House of Delegates of the Association.

#### ARTICLE IV.

Section 1. *Composition of the Association.*—This Association shall consist of members and delegates.

Sec. 2. *Members.*—The members of this Association shall be the members of the component county medical societies who have been certified to the headquarters of this Association, and whose dues and assessments for the current year have been received by the Executive Secretary.

Sec. 3. *Delegates.*—Delegates shall be those elected in accordance with this Constitution and By-laws to represent the component county societies in the House of Delegates of this Association.

#### ARTICLE V.

*House of Delegates.*—The House of Delegates shall be the legislative body of the Association, and shall consist (1) of delegates elected by the component county societies, and (2) the officers of the Association enumerated in Section 1 of Article VII.

#### ARTICLE VI.

Section 1. *Annual Session.*—The Association shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

Sec. 2. *Place of Meeting.*—The time and place for holding each annual session shall be fixed by the House of Delegates, or such authority may be delegated to the Council.

Sec. 3. *Special Meetings.*—Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

#### ARTICLE VII.

Section 1. *Officers.*—The officers of this Association shall be a President, a Vice-President, the Past President, a Treasurer and ten Councilors.

Sec. 2. The elective officers and councilors as defined in the preceding section, shall constitute the Council and shall be the board of trustees of this corporation. The Council shall have full authority and power of the House of Delegates between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws.

Sec. 3. *Election—Eligibility.*—The officers of this Association shall be elected by the House of

Delegates on the second day of the annual session. No person shall be eligible to an elective office who has not been a member of this Association during the preceding two years, and who is not a fellow of the American Medical Association.

Sec. 4. *Term of Office.*—The President shall serve one year. The Treasurer shall be elected for a term of three years. The term of office of Councilors shall be two years, five to be elected each year. All of these officers shall serve until their successors are elected and qualified.

Sec. 5. For the purpose of membership, the fiscal year of this Association shall begin on January 1 and end on December 31. Annual dues in the State Association shall be payable in advance.

#### ARTICLE VIII.

Section 1. *The Scientific Assembly.*—The Scientific Assembly of the Florida State Medical Association shall be the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine in its widest application.

#### ARTICLE IX.

*Seal.*—The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

#### ARTICLE X.

*Referendum.*—At any general meeting of the Association it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a vote of its members, submit any such question to the membership of the Association for its vote. For a final vote there shall be required a majority of all the members of the Association to determine the question.

#### ARTICLE XI.

*Amendments.*—The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates and officers registered at that annual session, provided that such amendment shall have been published in THE JOURNAL of the Association two months before the annual session, and that it shall have been sent officially by the Executive Secretary to each component county society at least two months before the annual session at which final action is to be taken.



## BY-LAWS

## CHAPTER I.

Section 1. All members of this Association shall have the right to attend all meetings and to take part in all of the scientific proceedings of the annual session.

Sec. 2. *Qualification.*—The name of a physician upon the properly certified roster of this Association shall be prima facie evidence of his right to register at the annual session.

Sec. 3. *Disability.*—No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association.

Sec. 4. *Members.*—This Association shall consist of one class of members. Members to be eligible to this Association shall be citizens of the United States and members of component county medical societies, including all of their classifications of local membership, whose dues and assessments in the State Association have been received from the secretary-treasurer of county societies by the headquarters of the State Association.

Sec. 5. *Dues.*—If any local society provides for a diversified classification of its members, dues for them in the State Association shall be collected and transmitted to the Executive Secretary of this Association or appropriated from the funds of the local society. Exempted from this provision are such local members as are still serving as hospital interns on full time on a nominal salary, and such as have retired from active practice of medicine.

Sec. 6. *Registration.*—Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Association. No member or delegate shall take part in any of the proceedings of the annual session, nor be entitled to any of the privileges or benefits of membership until he has complied with the provisions of this chapter.

## CHAPTER II.

Section 1. The Scientific Assembly shall hold its meetings at such time as the Council shall direct. No meeting of the Scientific Assembly shall be allowed to conflict with a general meeting.

Sec. 2. *Title of Papers.*—No paper shall be presented before the Scientific Assembly unless the title and an abstract which shall contain not less than thirty nor more than one hundred and fifty words is in the hands of the program committee at least sixty days before the first day of the annual session.

## CHAPTER III.

Section 1. *General Meetings—President's Address—Orations.*—The general meetings shall be open to all registered members and guests. Before them at such time and place as may have been arranged shall be delivered the annual address of the President, and the annual orations.

Sec. 2. *Time Limit of Papers.*—No address or paper before this Association except those of the President, and orators, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes.

Sec. 3. *Papers.*—All papers read before this Association shall be its property. Each paper shall be deposited with the Executive Secretary when read. Authors shall not cause papers read before this Association to be published as original elsewhere, nor until after they have been published in the official journal of this Association.

## CHAPTER IV.

Section 1. *House of Delegates.*—The House of Delegates shall meet annually at the time and place of the annual session of this Association.

Sec. 2. *Ratio of Representation.*—Each component county society shall be entitled to one delegate and corresponding alternate in the House of Delegates for each twenty full paid members in this Association, or major fraction thereof; provided, however, that each county society shall be entitled to at least one delegate and one alternate.

Sec. 3. *Quorum.*—A majority of the registered delegates and officers shall constitute a quorum. All of the meetings of the House of Delegates shall be open to members of the Association.

Sec. 4. *Committees of the House of Delegates.*—From among members of the House of Delegates the President for the purpose of expediting proceedings, shall appoint Reference Committees as follows: On Annual Reports, on President's Address, on Resolutions, to which shall be referred all resolutions introduced into the

House; a Committee on Credentials; tellers, sergeants at arms, and other committees considered by him to be necessary.

Sec. 5. *Funds*.—The House of Delegates shall provide funds for the expenses of the Association by a per capita assessment upon each of the county societies.

Sec. 6. *Expenses*.—The House of Delegates shall annually approve a budget of expense submitted to it by the Council.

Sec. 7. *Delegates to American Medical Association*.—The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-laws of that body.

Sec. 8. *Charters*.—The House of Delegates shall, upon application to and recommendation by the Council, provide and issue charters to county societies organized to conform to this Constitution and By-laws. Such charters shall be signed by the President and Executive Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with this Constitution and By-laws.

Sec. 9. *Multiple Societies*.—The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies, and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies.

Sec. 10. *Councilor Districts*.—The House of Delegates shall divide the counties of the state into ten Councilor Districts. A District society may be organized in any of these districts to meet at such a time or times as the society may fix between the annual sessions of the State Association.

The presidents of the county societies in each district shall be the vice-presidents of such district societies.

Sec. 11. *Special Committees*.—Any member who is in good standing in the Association may be appointed to serve on any committee created for a special purpose. All members of committees who are not members of the House of Delegates shall have the right to present their reports, in person, to the House of Delegates, and to participate in the debate thereon, but shall not have the right to vote.

## CHAPTER V.

Section 1. *Committee on Nominations*.—The House of Delegates on the first day of the annual session shall elect a committee on nominations consisting of ten delegates, one from each councilor district. The committee on nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of three members for the office of President, and of one member for each of the other office to be filled at that annual session. No two candidates for President shall be from the same district, and each candidate for Councilor must be a resident of the district for which he is nominated.

Sec. 2. *Nominations*.—The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the second meeting of the House.

Sec. 3. *Election of Officers*.—All elections of officers shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

Sec. 4. *Nominations From Floor*.—Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

## CHAPTER VI.

Section 1. *Duties of President*.—The President shall preside at the meetings of the Association and of the House of Delegates. He shall appoint by and with the consent of the Council, a committee of three from the Council, on Auditing and Appropriations, and a committee on Arrangements for the annual session. Each of these committees shall serve for a term of one year. He shall appoint all committees for the selection of which other provision is not made. He shall



deliver an annual address at such time, during the annual session, as may be arranged. He shall give a deciding vote in case of a tie. He shall be the chairman of the Council, and shall perform such other duties as parliamentary usage may require. He shall be a member of the Council for a period of one year immediately succeeding his term of office. He shall be ex-officio a member of all committees of the Association.

*Expense of President.*—The necessary traveling expenses incurred by the President in the line of duty herein imposed may be allowed by the Auditing and Appropriations committee, but this shall not include his expenses in connection with the annual session of this Association.

*Sec. 2. Vice-President.*—The Vice-President shall be a member of the Council, and shall act as President in the absence or disability of the President. If the office of President should become vacant the Vice-President shall succeed to the presidency.

*Sec. 3. Treasurer.*—The Treasurer shall give bond, at the expense of the Association, in such an amount as shall be required by the Council. He shall be the financial agent of the Association. He shall receive all funds due the Association from every source whatever, except accounts due THE JOURNAL in the conduct of its business. He shall deposit the funds in a bank of deposit in the name of the Florida State Medical Association. He shall keep a complete set of books concerning the receipts and expenditures of the Association, except those of THE JOURNAL. He shall, under direction of the House of Delegates, sell or lease any estate belonging to the Association and execute the necessary papers. He shall pay money out of the treasury upon voucher as directed by the Auditing and Appropriations committee, (Chapter VII, Section 5), and shall render a monthly trial balance of his accounts to the chairman of the Auditing and Appropriations committee and to each member of the Council.

*Sec. 4. Executive Secretary.*—The Executive Secretary shall be ex-officio the secretary of the Association and all its committees. He shall be the executive agent of the Association transacting its business under the direction of the officers of the Association. He shall collect all dues from members of the Association through the secretaries of the component societies, and pay them to the Treasurer. He shall be the business manager and news editor of THE JOURNAL. He shall pay over the profits of THE JOURNAL at the end

of each fiscal year, or whenever ordered to do so by the Auditing and Appropriations committee or by the House of Delegates. Whenever the income of THE JOURNAL does not meet its expense, he shall make requisition, which must be approved by the Auditing and Appropriations committee, on the Treasurer for the necessary amount. He shall have charge of the business offices of the Association and may employ such aid as shall be authorized by Council. He shall be custodian of all record books and papers belonging to the Association, except those of the Treasurer. He shall provide for the registration of the members and delegates to the annual session. He shall provide for the reporting of the proceedings of the several sessions. He shall conduct the official correspondence notifying members of meetings, officers of their election, committees of their appointment and duties, and shall perform such other duties as may be assigned to him by the Council. He shall give bond, at the expense of the Association, in such amount as shall be required by Council.

## CHAPTER VII.

*Section 1. Council Meetings.*—The Council shall hold daily meetings during the annual session of the Association, and at such other times as necessity may require, subject to the call of the President or on petition of three Councilors. It shall meet on the last day of the annual session of the Association for re-organization. At this meeting it shall elect a secretary who shall keep a permanent record of its proceedings. It shall cause to be published in THE JOURNAL of the Association, a record of its meetings and actions.

*Sec. 2. Duties, Individual.*—Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members, and to keep in touch with activities of and aid in the betterment of the various societies.

*Sec. 3. Expenses of Councilors.*—The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed by the committee on Auditing and Appropriations, but this shall not include his expenses in attending the annual session of the Association.



Sec. 4. *Duties, Collective.*—The Council shall be the executive body of the House of Delegates and shall, between sessions, exercise the powers conferred on the House of Delegates by this Constitution and By-laws.

The Council shall be the board of censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or of a county society. Its decision in all cases, including questions regarding right of membership in this Association, shall be final, except that an appeal may be made to the House of Delegates.

Sec. 5. *Auditing and Appropriations Committee.*—The President shall appoint three members of the Council, a committee on Auditing and Appropriations, as provided in Chapter VI, Section 1 of these By-laws. The duties of this committee shall be: To prescribe the method of accounting and to audit any or all accounts of the Florida State Medical Association. The committee shall prepare and present to the Council for action at its first meeting in January of each year, a budget providing for the necessary expenses of the Association. Any surplus or balance of funds for the year shall go into the general fund for re-apportionment.

Sec. 6. *Committee on Arrangements.*—The Committee on Arrangements for the Annual Meeting shall consist of three members of Council to be appointed by the President, as provided in Chapter VI, Section 1 of these By-laws, at least six months in advance of the annual session. On recommendation of this committee, the Council shall appoint a general chairman of a local auxiliary committee on arrangements, who, together with the president of the local county medical society, shall appoint and organize the personnel from among the members of the society in the county in which the annual meeting is to be held. The auxiliary committee shall, through the committees of its own selection, provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements and Council. All receipts accruing from the annual session shall be turned over to the Com-

mittee on Arrangements, and all expenditures in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations. Immediately following the annual session, the Committee on Arrangements shall forward to the Treasurer of the State Association any accumulated balance. It shall meet any deficit by application to the Council, through the Committee on Auditing and Appropriations.

Sec. 7. *Vacancies.*—The Council shall by appointment fill any vacancy in office occurring in the interval between the annual sessions of the House of Delegates. The appointee shall serve until his successor has been elected and qualified.

Sec. 8. *Program.*—The Council shall determine the character and scope of the scientific proceedings of the Association for each session. At least thirty days previous to each annual session, it shall prepare and issue a program, announcing the order in which papers, discussions and business of the House of Delegates shall be presented. This program shall be adhered to by the Association as nearly as practicable.

Sec. 9. *Executive Secretary.*—The Council shall employ an Executive Secretary, who need not be a physician, nor a member of the Association.

Sec. 10. *Salaries.*—The salaries of all employees of the Association shall be fixed by Council.

Sec. 11. *Headquarters.*—The Council shall provide such state headquarters for the Association as may be required to properly conduct its business.

## CHAPTER VIII.

Section 1. *Standing Committees.*—The Standing Committees of the Association shall be:

1. A Committee on Public Policy and Legislation.
2. A Committee on Publication.
3. A Committee on Medical Education and Hospitals.
4. A Committee on Medical Economics.

Each of these committees shall consist of three members, each of whom shall serve for a term of three years. One member of each of these committees shall be appointed annually by the President, by and with the consent of the House of Delegates, provided that at the 1926 annual session one member of each of the foregoing committees shall be appointed for a term of three years; one each for two years, and one each for one year.

Sec. 2. *Public Policy and Legislation.*—The Committee on Public Policy and Legislation shall consist of three members, one of whom shall be appointed each year, and the President and the Vice-President. This committee shall meet annually, or as may be necessary. This committee shall represent the Association in securing and enforcing legislation in the interest of public health and of scientific medicine.

Sec. 3. *Publication.*—The Committee on Publication shall consist of three members, one of whom shall be appointed each year. The Committee shall have referred to it all reports on scientific subjects, and all scientific papers and discussions heard before the Association. It shall be empowered to curtail, abstract or reject papers and discussions. The committee shall have authority to arrange for the publication and distribution of THE JOURNAL.

Sec. 4. *Medical Education and Hospitals.*—The Committee on Medical Education and Hospitals shall consist of three members, one of whom shall be appointed each year. This committee shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, on behalf of the Florida State Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

Sec. 5. *Medical Economics.*—The Committee on Medical Economics shall consist of three members, one of which shall be appointed each year. It shall investigate all matters affecting the economic status of physicians and shall report annually to the House of Delegates such recommendations as may, in its judgment, seem proper.

Sec. 6. *Reports.*—Reports of the standing and special committees shall be published in the official journal of the month preceding the date of the annual session of this Association, and these reports must be in the hands of the Executive Secretary sixty days in advance of the annual session.

#### CHAPTER IX.

Section 1. *Assessments.*—The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the officers of the Association the dues and assessments for its members, together with

such data as shall be required for a record of its officers and membership.

Sec. 2. *Receipts of Dues—Qualifying Membership.*—The record of payment of dues and assessments on file in the offices of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

Sec. 3. *Penalty for Failure to Remit.*—Any county society which fails to make the reports required, at least thirty days before the annual session of the State Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

#### CHAPTER X.

*Ethics.*—The ethical principles governing the members of the American Medical Association shall govern members of this Association.

#### CHAPTER XI.

The deliberations of this Association shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

#### CHAPTER XII.

Section 1. *County Societies.*—All county societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the House of Delegates, receive charters from this Association, provided that their Constitution and By-Laws shall have been submitted to the Council and received its approval.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. *Qualifications.*—Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Association. Every reputable and legally qualified physician who does not practice, nor profess to practice sectarian medicine, and who is not affiliated with any organization which aims to foster an exclusive dogma in therapeutics, and who is a bona fide resident of the same county, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from

membership automatically as of the date of revocation. The Council of the State Association shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

Where it is more convenient for a member to attend the meetings of the component county society in an adjoining county, upon request of the society in the county of his residence, his membership may be transferred and accredited to said adjoining county society.

Sec. 4. *Appeals*.—Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him, shall have the right to appeal to the Council. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Association for final determination.

Sec. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the Councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

Sec. 6. *Removals*.—When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Association to the end of the period (respectively) for which his dues have been paid.

Sec. 7. *Functions and Duties*.—Each county society shall have general direction of the affairs of the profession in the county, and its influence

shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

Sec. 8. *Certification of Delegates*.—At some meeting in advance of the annual session of this Association, each component county society shall elect delegates and individual alternates therefor to represent it in the House of Delegates of this Association, in accordance with Chapter IV, Section 2 of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the Executive Secretary of this Association at least thirty days before the annual session. Representatives in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Sec. 9. *Roster of Members*.—The Secretary of each county society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district Councilor and to the Executive Secretary.

### CHAPTER XIII.

Section 1. *Amendments*.—These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been published in THE JOURNAL two months before the annual session.

Sec. 2. *Repeal*.—Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

All of which is respectfully submitted.

JOHN S. HELMS,

Chairman Executive Committee.

FIFTY-THIRD ANNUAL MEETING OF  
THE FLORIDA MEDICAL ASSOCIATION  
WILL BE HELD AT  
GAINESVILLE, MAY 3rd, 4th and 5th



## The Journal of the Florida Medical Association

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our association and the State University. Let us acquaint ourselves with our University during our visit to Gainesville.

Every facility for comfortably housing the members of the Association is assured.

Printed in this issue is an article by Dr. Murphree, President of the University, which within itself should stimulate attendance.

## THE GAINESVILLE MEETING

Gainesville is planning an elaborate reception for the members of the Florida Medical Association. The local committee for months past has been diligently planning to make the Fifty-fourth Annual meeting the most successful. The intellectual capital of the state is a site befitting the rendering of such a program as is being prepared by the Scientific Program Committees. An opportunity to know our State University will be afforded during our stay in Gainesville and will materially assist in a close cooperation between

## INCREASE IN THE ANNUAL ASSOCIATION DUES

Attention of the members of the Florida Medical Association is called to the following proceedings of the House of Delegates of the Association at their last meeting. The following is extracted from the proceedings as recorded by the official stenographer and appearing in the Journal of the Florida Medical Association, Volume 11, Nos. 9, 10, 11 and 12, June, 1925.

Page 220, May 19, 1925: "Motion by Dr. Henson that the By-Laws providing for annual dues, which now reads: 'Shall be \$5.00 per annum,' be amended to read: 'Shall be \$10.00 per annum.'"

"In accordance with the provisions of the By-Laws, the proposed amendment was laid upon the table until the following day."

Page 221, May 20, 1925: "Motion to amend the By-Laws, and thereby raise the annual dues from \$5.00 to \$10.00 was seconded and carried."

The increased cost of the publication of THE JOURNAL and the necessity of employing a Business Manager for the Association has made the increase in dues imperative. The Executive Committee in the Annual Report made by Dr. John S. Helms as Chairman, at our last Annual Meeting, strongly advocated the increase in dues and it was following this that the House of Delegates voted to make the change.

Many State organizations are employing lay-secretaries with success. Ohio and Wisconsin have profited greatly by such a measure. With the growth of THE JOURNAL and the Association it is impossible for a busy practitioner to conduct the business affairs of our organization.

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The Erie County Medical Society of Pennsylvania has undertaken a rather unique means of preventing as nearly as possible the promiscuous calling of their members for unnecessary night work. Our County Medical Societies would probably profit by adopting a similar method. The following letter has been forwarded to each of their members:

#### ERIE COUNTY MEDICAL SOCIETY

Dear Doctor:

Do you like to have your patients call you in the evening and on Sunday and holiday afternoons when they could just as well have called you earlier? Or do you like to have these hours to yourself?

There is only one way to get people out of the habit of eternally spoiling your evenings and Sundays and that is by charging them more. The Erie County Medical Society proposes to make it easy for you to get people into better habits.

The inclosed slips embody the sense of the resolution adopted unanimously at the January meeting. We suggest that you put one of these slips into each bill you send out and that you carry a few in your bag to leave with people

who call you in the evening or afternoons or Sundays and holidays.

The Society is also putting a large "ad" in all the Erie papers, both English and foreign press, to run once a week for six weeks covering this subject. By these means, your patients will readily see that it is nothing personal upon your part when you charge the extra fee, and we are sure that by earnest cooperation on your part that in a few months you will be making most of these calls in the day time and the luxury of the evening and Sunday afternoons will be yours.

Extra slips furnished on request.

Erie County Medical Society.

Attached to the letter is the following notice to patients:

#### PHYSICIANS' NOTICE TO THE PUBLIC

If in need of a physician, call him if possible between the hours of 7 a. m. and 6 p. m.

Upon Sundays and holidays, try to put your calls in during the morning hours.

Calls after 6 p. m. on week days and on the afternoons of Sundays and holidays, such as Christmas, New Year, Decoration Day, July 4th, Labor Day and Thanksgiving Day are 1/3 higher. Calls from 11 p. m. until 7 a. m. are 2/3 higher.

Erie County Medical Society.

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Dr. C. Eugene Riggs, professor emeritus of Neuro-Psychiatry, University of Minnesota, read a paper entitled "The Dynamics of Personality" before the Duval County Medical Society at their last monthly meeting.

#### STATE NEWS ITEMS

Doctor and Mrs. H. Mason Smith of Tampa are being congratulated on the arrival of a fine son.

Dr. C. C. Coleman of Richmond, Virginia, was a recent visitor in Jacksonville.

Gov. John W. Martin has appointed Dr. S. E. Driskell of Jacksonville a member of the State Board of Medical Examiners.

The Dade County Medical Society recently voted to raise their annual dues to \$50.00.

The members of the Association are deeply grieved to learn of the death of Dr. J. Harry Walters of Ocala. Dr. Walters was very active in State Medicine and a beloved physician in his community.

Dr. J. Lee Kirby-Smith of Jacksonville expects to spend several months in European clinics.

Jacksonville is assured another modern and up-to-date hospital. It is understood that five hundred thousand dollars is to be expended in the erection of a new plant for St. Vincent's Hospital. Hospital facilities in Jacksonville and Florida are far from commensurate with the population. The building of new hospitals is welcomed by the medical profession.

#### ADVERTISING NOTES

**NEW SILVER COMPOUNDS**—The silver salts have lost none of their prestige, notwithstanding the flood of topical antiseptics and germicides which is overflowing the market. On the other hand, certain improvements are being made with the object of avoiding the irritating or staining feature of the older silver compounds.

By an ingenious combination of silver iodide with a gelatinous proteïn, this salt has been made impervious to the action of sunlight, so that its solutions (or suspensions) do not turn dark on exposure. Thus the staining effect of the silver is avoided. And it would appear from bacteriologic tests made by the manufacturers (tests which, of course, any bacteriologist can repeat) that the germicidal activity of the new silver preparation is at least equal to that of pure carbolic acid; moreover, that, whatever the concentration of the solution, inflamed tissues are not irritated by its application.

The name of the product referred to is Neo-Silvol, and the manufacturers are Parke, Davis & Co. Some of the applications of Neo-Silvol are mentioned in an advertisement which appears in this issue.

**RESEARCH RESULTS.**—Recent research in the field of medicinal chemistry, coupled with scientific physiological and clinical investigation, is effecting profound changes in the practice of medicine.

Discoveries have already been announced which are changing the methods of treating diabetes, high blood pressure, and syphilis. So promising is the research work now being carried on in universities, and by large pharmaceutical manufacturers, that further important discoveries may soon be expected. It is not too much to hope that definite discoveries may even

be made in the field of cancer and tuberculosis.

During the past year, announcement of the discovery of several new and important medicinal chemicals has been made by the Research Department of the Abbott Laboratories, North Chicago, Ill. Among these discoveries are Butesin Picrate, a new chemical body, combining both anesthetic and antiseptic properties.

Other important research results from the Abbott Laboratories are Butyn and Benzyl Fumarate, both of which are fully described in "New and Non-Official Remedies."

During the past ten years the following important Council-Passed medicinal chemicals have been manufactured by, and added to the list of the Abbott Laboratories: Anesthesin, Acriflavine, Barbital, Chlorazene, Dichloramine-T, Cinchophen, Neocinchophen, Neutral Acriflavine, and Procaine.

These notable additions to the list of American-made, medicinal chemicals promise much for the future cordial relations between scientific, manufacturing chemistry and progressive medical practice.

**THE GROWING IMPORTANCE OF GELATINE IN INFANT FEEDING.**—Some time ago, Dr. Joseph Leidy, of Philadelphia, said: "The combination of gelatine and milk in infant feeding was long used by my father and the late Dr. W. Pepper. I have continued to use it during the past thirty years, and am of the opinion that it gives results when many other combinations fail."

In recent months the growing interest of the medical profession in gelatine has been noticeable. Doctors are reporting gratifying successes in preventing such infant ailments as milk colic, regurgitation, vomiting, diarrhœa, excessive gas formation and constipation by 1% addition of gelatine to the milk diet.

Thomas B. Downey, Ph. D., Fellow of the Mellon Institute, Pittsburgh, has, by standard feeding tests, determined that the addition of pure, plain unflavored gelatine increases the nourishment obtainable from milk by about 23%.

In discussing the digestibility of milks, especially by infants and young children, Alexander and Bullowa have pointed out that the protein content may not be considered as a unity because it is composed of two proteins, casein and lactoalbumin, with entirely dissimilar properties. Casein is an irreversible colloid exceedingly susceptible to coagulation by acid and rennin, while



lactoalbumin is reversible and serves to protect the former.

Analysis shows that mother's milk contains a high proportion of lactoalbumin, the casein being adequately protected. Mother's milk is resistant to coagulation by acids and rennin and its greater acceptability as the food for the infant is reflected by the low mortality where the young are breast-fed. On the contrary, cow's milk contains a high proportion of casein and relatively little lactoalbumin; it is poorly protected. In consequence, the casein of cow's milk is very susceptible to coagulation by acids and rennin. The mere coagulation of the casein is not the whole story, because the coagulum carries down much of the fat present, yielding masses that have a tendency to cohere and are of a texture that is quite resistant to penetration by the digestive juices. The voiding of such masses occurs too frequently in artificial feeding; nutrients are lost to the organism and it is quite probable that decomposition products of an undesirable nature are formed within these undigested curds.

This is in no way a reflection on the great nutritive value of cow's milk which is indispensable but simply emphasizes the deterrent condition it meets in the human stomach which must be neutralized to insure the complete assimilation of the milk nutriment.

From this viewpoint an obvious modification in artificial feeding is the protection of the unstable casein by the addition of suitable protective colloids.

It is of interest to give careful attention to gelatine in this place. As previously mentioned, its colloidal protection is of the highest order. It is also an excellent emulsifying agent and may function as such in either an acid or an alkaline medium. It is a common product of exceptional purity, and is an easily digested protein which is readily combined with milk. In combination with milk, the protein content is increased, food value is increased, volume is not appreciably increased and digestibility is increased. Theoretically the employment of gelatine in the child dietary is sound, and laboratory experimentation and clinical experience substantiate these conclusions.

The approved method of combining gelatine with milk is as follows:

Soak, for ten minutes, one level tablespoonful of pure, unflavored, unsweetened gelatine (Knox) in one-half cup of cold milk taken from the baby's formula; cover while soaking; then place the cup in boiling water, stirring until gelatine is fully dissolved; and add this dissolved gelatine to the quart of cold milk or the regular formula.

It must be remembered that there is a great difference in gelatine. Realizing the importance of absolute purity in any gelatine that is combined in milk or used in any way in the dietary, the laboratories of the Charles B. Knox Gelatine Company maintain a strict and constant control of the production of Knox Sparkling Gelatine. No sweetening, artificial flavor, or coloring, is ever added to this product.

## ABSTRACT DEPARTMENT

### SURGERY

The Use of Diathermy and of the Quartz Lamp for Conserving the Temperature of the Viscera and Promoting the Welfare of the Patient Before and After Abdominal Operations. Crile, G. W. Surgery, Gynecology and Obstetrics, 1926, XLII, 218.

The trend of the best surgical thought for the past few years has been along lines of Physiology, and the preservation of normal physiological processes in the various organs and systems, during and after surgical procedures, in order to still further lower surgical mortality, and to make surgical intervention less and less of an ordeal for the human body to undergo. It is therefore interesting and advantageous to us to summarize some recent work done at the Cleveland Clinic and published in the paper referred to above.

Upon the proven grounds that the liver is essential to life; that the metabolic and chemical functions of this essential organ are dependent for their successful consumation upon the maintenance of certain degrees of temperature in this organ; that these processes are decreased 10% for each degree of lowering of the liver temperature; and that the liver temperature is lowered from exposure of the abdominal viscera, in proportion to the amount and time of the exposure, Crile and his associates have made use of the physical power of Diathermy to maintain and to increase the temperature of the liver during and after operations upon this organ and its accessories, and in other abdominal operations. The agent has also been used as an adjunct to

postoperative care of patients in the following ways:

First, to continue maintaining the temperature of the liver; second, to raise the general body temperature in shock, by passing the current from one foot through the body to the other foot; and thirdly, to maintain the normal temperature in the lungs in the prevention of pneumonia as a postoperative complication.

They feel that a good many bad risk cases are being given just that additional chance for life by this procedure which means the difference between life and death, in the cases which are hovering on the border line between the two.

J. K. S.

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Diagnosis and Treatment of Fracture of the Skull as Developed in The Cincinnati General Hospital—*Annals of Surgery*, Feb., 1926, Vol. LXXXIII, No. 2, Pg. 182.

Carter gives in a most practical manner the experience at the Cincinnati General Hospital in the handling of 223 cases of fracture of the skull. Omitting the discussion of pathology in these injuries he enters directly upon the problem from the point of view of the physician who is confronted with a patient suffering from a fractured skull. He does discuss the importance of the state of consciousness, the pulse, the temperature, the respiration and the neurological functions as the indicators of the severity and type of lesion. His observation of these points are of most valuable aid to the physician. With the knowledge gained from these one can usually give an accurate prognosis and can decide upon the proper line of treatment. The making of such observations constitutes what he calls the "observation period." This, he says, "is the most important phase of the treatment."

Spinal tapping Carter advocates strongly, not only as a diagnostic aid but also for its therapeutic value in selected cases. All simple fractures, except those with very mild symptoms, are subjected to spinal puncture. In the presence of moderately high pressure these are repeated until the pressure remains normal. When there is evidence of high intra-cranial tension and high spinal pressure, which is relieved only slightly or temporarily by the puncture, decompression by operation is indicated. If puncture lowers high tension and pressure without relief of the patient's general symptoms, decompression seems of no value, as the injury is one of the brain itself rather than pressure on the brain. He believes that very high intra-spinal pressure

with clear fluid to be a diagnostic of extra-dural hemorrhage.

Operative treatment consists in debridement of compound fractures, craniotomy for intracranial hemorrhage, and subtemporal decompression in fractures without local symptoms, but with a high intracranial pressure. Operation has been resorted to in only 56 of the 223 cases.

It is important that we keep in mind the keynote of the paper as expressed in the last sentence: "The most important phase of the treatment is the period of observation, when one views the changing train of events, weighs the importance of each, and directs his therapy accordingly." E. J.

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## DERMATOLOGY

"Bismuth Salicylate in Experimental Rabbit Syphilis. A Study of Toxicity, Absorption, Elimination and Spirocheticidal Power," O. M. Gruhitz, M.S., M.D. *Archives of Dermatology and Syphilology*, Feb., 1926, Vol. 13, No. 2.

In an article well illustrated with charts, roentgenograms, and photographs, the author enters into the history of the use of bismuth and its salts in the treatment of syphilis in humans and gives a clear, concise record of the use of bismuth salicylate in the treatment of syphilitic rabbits, and the various effects of the drug as observed when administered to dogs.

The summary of the work done is quoted verbatim.

## SUMMARY

Absorption, elimination, toxicity and spirocheticidal power of bismuth salicylate has been studied.

The bismuth preparations are absorbed relatively slowly. Absorption of bismuth salicylate is more rapid than that of metallic bismuth suspensions, and is the same as that of potassium bismuth tartrate or sodium potassium bismuth tartrate.

From the total amount of bismuth eliminated, from 77 to 92 per cent. was found in the urine and from 23 to 8 per cent. in the feces.

The elimination reaches a maximum with single doses in about five days and in about ten days with fractional administration. Following the initial maximum elimination the rate of elimination becomes fairly uniform, but is greater with larger doses administered.

A fairly uniform rate of elimination increasing with increased dosage tends undoubtedly to avoid cumulative effect.

The toxicity of bismuth salicylate is comparatively low. A dose of 2 gm. of body weight per kilogram appears to be toxic, with severe injury to the kidneys and liver. A dose of 1 gm. per kilogram appears to be readily tolerated and only a mild degree of injury was noted to the kidneys and the liver.

A therapeutic cumulative dosage of .5, 1, 1.5 and 2 mg. per kilogram per eight to eleven injections produced no loss of weight or histologically demonstrable lesions in the kidneys and the liver of experimental rabbits.

The gain in weight of the treated rabbits with cumulative therapeutic doses was considerably more following cessation of treatment than during the period of treatment.

Albuminuria has never been found in dogs receiving 2, 8.4 and 24 mg. of bismuth salicylate per kilogram of body weight.

Blood urea nitrogen in dogs receiving a single treatment of 8.4 and 24 mg. per kilogram, respectively, and a cumulative therapeutic dose of 2 mg. per kilogram, or a total of 408 mg., remained within the normal limits.

Bismuth salicylate in 5 mg. per kilogram rendered the lesions free from spirochetes in 48 hours. A 3 mg. dose produced similar results in generalized orchitis, but not on sclerotic gumma.

A cumulative dosage of 2 mg. per kilogram rendered the lesion free following the second administration in from four to seven days.

Doses of 1 and 1.5 mg. per kilogram rendered the lesion free in seven days, and .5 mg. doses in some cases appeared equivalent to 1 mg., in other cases it took about twenty days before the spirochetes disappeared.

J. L. K. S.

FIFTY-THIRD ANNUAL MEETING OF  
THE FLORIDA MEDICAL ASSOCIATION  
WILL BE HELD AT  
GAINESVILLE, May 3rd, 4th and 5th.





*500 Times More  
Germicidal than Phenol—*

## Metaphen

*A Contribution of Research to Medical Practice*

For years, chemists in the Dermatological Research Laboratories have been engaged in the study of organic mercurials, particularly in regard to their germicidal properties. The result of this research is METAPHEN.

This powerful, mercurial antiseptic is not only 500 times more germicidal than phenol, but is *stainless, odorless, noncorrosive* and *practically nonirritating*.

METAPHEN is the ideal antiseptic and germicide for general surgery due to its exceedingly powerful destructive effect upon bacteria, particularly the staphylococci, streptococci and gonococci.

METAPHEN is decidedly superior to iodine for sterilizing the operative area as well as for treating wounds and infected surfaces. It is an ideal sterilizing agent for surgical instruments.

METAPHEN is also giving remarkable results in eye, ear, nose and throat work as well as in dentistry and general practice.

Ask your dealer or druggist for METAPHEN, D.R.L. Interesting literature will be sent on request to

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## HELIOTONE the Simplified Therapeutic Lamp

The Heliotone Lamp has been designed to meet the requirements of the modern office. After months of careful research, it has been offered to the medical profession as a distinct improvement over any therapeutic lamp heretofore offered. The chief factor of the Heliotone Therapeutic Lamp is its efficiency and ease of operation. Very sturdy in construction, yet very light, it is easy to manipulate during treatments. The special disk mounted at the top of the upright standard is new and assures the success of this lamp.

Write for special circular fully describing this new therapeutic appliance.

### Thirty Days Free Trial

The Heliotone Therapeutic Lamp is unconditionally guaranteed and will be shipped to you on a thirty day free trial. If the lamp proves unsatisfactory, it can be returned at our expense. If satisfactory, you may either remit the purchase price in cash or handle it on the 10 easy monthly payment plan.

9CJ2385. Heliotone Therapeutic complete for 110 Volts A. C. or D. C. \$55.00

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*A visit from the Squibb  
Professional Service  
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"Doctor Haynes, do you not find it inconvenient to prepare your own solutions of arsphenamine?"

"Yes, but I feel obliged to do so as thereby I am assured a safe product for administration."

"Would it not be a great saving of your *time* and *labor* if you could obtain, *already prepared* and *ready to inject*, a *safe* solution of Arsphenamine marketed under the *Squibb Label*?"

"It certainly would. Is there such a product?"

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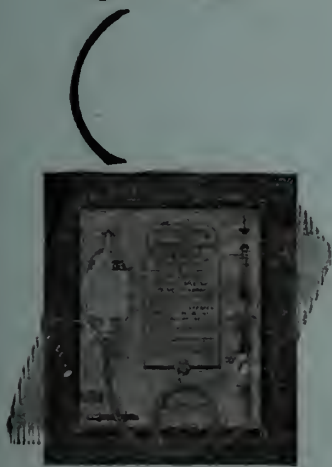
**SOLUTION OF ARSPHENAMINE SQUIBB.**

"This preparation is a pure, stable and accurately alkalized, aqueous solution of Arsphenamine Squibb. The entire process of preparing the solution is conducted under nitrogen or vacuum, thus eliminating any danger of oxidation.

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"SOLUTION OF ARSPHENAMINE SQUIBB is sold in 80-cc. and 120-cc. ampuls containing 0.4 and 0.6 Gm. of Arsphenamine respectively. The *apparatus* for injection, consisting of a sterilized needle, tubing and filter bulb, is supplied in a separate package, complete and ready for immediate use."

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.





# NEO-SILVOL

A Colloidal Compound of Silver Iodide

*Cleanly, Non-irritating, Germicidal*

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## GASTRIC SYPHILIS\*

J. KNOX SIMPSON, M.D.,

Jacksonville.

Because of several unusually interesting points arising in connection with a case of gastric syphilis which has come into our hands in the recent past, I wish to bring it to your attention with a few references to the subject in general, the report of our case, and some comments upon the interesting points which it brings up.

Contained in a paper by Brans and Bloch, from the Michael Reese Hospital of Chicago, published in the *American Journal of Syphilis* for July, 1924, the following statement was considerably surprising to me:

"A study of the literature to the end of the year 1923 revealed but seventeen cases in which the anatomic description was sufficiently complete to base a diagnosis of gastric syphilis. This small number of anatomically proved cases of syphilis of the stomach is in striking contrast to the two hundred and fifty or more cases reported, in which the diagnosis was based solely on clinical evidence or the results of antiluetic treatment."

In adding then our case, which I feel is undoubtedly an anatomically proved one, we feel that we are at least shedding some slight additional light upon the subject.

The pathology of gastric syphilis may be manifested by either a general or a circumscribed deposition of fibrous tissue in the stomach. It is a tertiary lesion, coming late in the disease, and carries with it the same characteristic deposition of fibrous tissue as mark similar lesions elsewhere in the body. There may at times be breaking down in the center of a circumscribed gumma, causing ulceration, and producing a lesion which is hard to differentiate from chronic caloused ulcer or carcinoma.

The four requisites for a diagnosis as laid down by Chase are:

1. Positive Wassermann reaction.
2. Evidence of other syphilitic lesions.
3. Demonstration of a lesion in the stomach by the radiograph.

4. Therapeutic improvement.

The case which we wish to report fulfills the above requirements with the exception of the fact that the Wassermann was negative at the time. It also has the additional value of operative inspection of the growth.

The record of the case is as follows:

Male—46 years of age; merchant. Family history entirely negative. Referred to me in July, 1923, by Dr. Stanley Erwin, with the following history:

Present complaint was of periodic spells of nausea and vomiting, the vomitus consisting of large quantities of fluid and food remnants. The attacks accompany severe darting pains through the trunk and abdomen requiring morphine for relief of the pain, and gastric lavage with hot soda solution for relief of the nausea and vomiting. The first attack referable to the stomach occurred in 1920 and was thought to be acute indigestion. The second stomach attack developed in 1922 and was diagnosed gastritis. The present attack developed early in July, or about a month prior to the time I first saw the patient, and had been present constantly and of increasing severity since. Dr. Erwin discovered a pulsating mass of the expansile type in the epigastrium, over which was heard a distinct bruit when the patient was examined early in the present attack.

The past history shows the usual diseases of childhood, with nothing of interest until 1896 (27 years prior to this examination) when he contracted syphilis. He had rather dilatory and inappropriate treatment at that time. Ten or twelve years later he began to have evidences of neurosyphilis, and first consulted Dr. Erwin in 1912, at which time he had a flaccid paralysis of the left arm and leg; inability to walk without the use of a cane, to walk at all in the dark, and to enunciate his words distinctly. At this time the blood Wassermann was negative, and the Spinal Fluid Wassermann four plus. Ten Salvarsan injections, some mercury, and one Swift-Ellis spinal treatment were given at this time, and the condition almost completely cleared up. Since then thirty to forty Salvarsans or Neosalvarsans have been given each year. In 1918, in a sanatorium in the North, three Swift-Ellis

\*Read before the Duval County Medical Society, Jacksonville, November 11th, 1924.



Spinal treatments were given. In 1920 both spinal fluid and blood Wassermanns were negative, and have remained so.

He had a right lobar pneumonia in 1922, followed by a suppurative right antrum infection which was drained six months later.

At intervals during this rather prolonged anti-syphilitic treatment he has had recurring manifestations of involvement of the nervous system, lightening pains in the extremities, visceral pains, inability to control bladder mechanism at time, etc.

The examination at the time we first saw him showed a poorly nourished, thin male, whose face appeared drawn and anxious. There was twitching about the mouth and nose and evidence of nervousness. The skin was sallow, smooth, and showed no scars. Eyes rather prominent, pupils contracted, sluggish and surrounded by a thin white line in the iris.

Tongue protrudes in mid-line. Neck negative. Chest normal shape and contour, lungs negative. Heart slightly enlarged to left, mitral regurgitant murmur. Extremities normal. No glandular adenopathy. All reflexes absent in lower extremities, except for positive Babinski and Romberg signs.

The abdomen is flat, well muscled, rather generally tender and sensitive to palpation, especially in the epigastrium, and the site of generalized voluntary muscular rigidity. There is a rounded mass the size of a tangerine orange, palpable in the mid-epigastric region, which pulsates coincident with the abdominal aorta, and is apparently rhythmically expansile. Abdominal examination is otherwise negative.

He was referred to Drs. Cunningham and Shaw for X-ray study of the gastrointestinal tract, as a result of which study the following report was submitted:

"Two glasses of a thick barium meal were taken freely and were seen to pass through the esophagus into the stomach and fill the cardiac end in normal fashion. There was immediately seen a large round pressure defect, involving the entire lower end of the stomach. As soon as the meal was taken, close observation showed the stomach pulsating synchronously with the pulse. There was no definite tumor mass seen, but the depression on the pyloric end of the stomach seems to result from some soft tissue organ about the size of an apple. The walls of the stomach along the edge of the depressed outline are rather

ragged, and give the impression of some intrinsic gastric lesion, in addition to marked pressure from without. There is practically a complete pyloric obstruction, as after two hours' observation a very small amount of barium had passed through the pyloric end despite violent peristalsis throughout the study. In some films the appearance of an annular lesion involving the pylorus was noted.

Resume: Aneurism of the abdominal aorta, producing pressure at the pyloric end of the stomach. An obstructive organic lesion of the pyloric end of the stomach. This may be intrinsic or extrinsic and probably both. If extrinsic it probably results from adhesions to the aneurismal sac at this point.

The clinical laboratory examinations showed no abnormal findings.

A tentative diagnosis of aneurism of the abdominal aorta, producing secondary pyloric obstruction, was made and exploratory operation with the hope of establishing at least palliative drainage of the stomach was advised, and the advice accepted.

Upper abdominal section was done under novocain nerve block anaesthesia. Upon opening the abdomen a yellowish colored, translucent, smooth, firm mass, the size of a small orange, was seen to involve the lower border of the left lobe of the liver and the pyloric end of the stomach. It was not hard nor nodular, and there were no enlarged glands in the gastrocolic omentum. The mass was continuous from liver to stomach, there being no dividing line between the two organs at this point. The entire gastro-hepatic gummatous mass was firmly fixed, and prevented access to the posterior stomach wall. It occupied a position directly overlying the abdominal aorta, the pulsation of which was transmitted to it. Operative diagnosis of gumma of the stomach and liver was made. An anterior gastroenterostomy was done and the abdomen was closed.

Aside from some rather troublesome retention of urine after the operation, the patient made a smooth recovery and was discharged from the hospital ten days later.

He had insisted before the operation that it was impossible for him to take mercury, but afterward he consented to do this and Dr. Erwin put him on continued, vigorous mixed treatment. His further convalescence was quite gratifying: his stomach symptoms disappeared, and exami-



FIG. 1  
Drawing showing the gummatous mass involving the left lobe of the liver and the pyloric end of the stomach.

nation, including further X-ray study, three months later, showed an entire disappearance of the palpable mass and only slight X-ray evidence of deformity of the pylorus, no more than could be accounted for by resulting scar tissue.

In summing up the points of particular interest in this case I would like to discuss them briefly from the standpoints of both diagnosis and treatment.

You will recall that our preoperative and postoperative diagnosis did not agree. This was due to a peculiar combination of findings which were wrongly interpreted. The mass gave a very typical sensation of the expansile type of pulsation to the palpating fingers, a bruit to auscultation, and when viewed with the fleuroscope, in the presence of a stomach filled with barium,

there was a most beautiful demonstration of a filling defect which became larger and smaller, like the opening and closing of the light diaphragm on a microscope, coincident with the pulsation of the abdominal aorta. Changing of the position of the patient did not alter this effect. In addition to this fact, the defect gave the impression of extra-gastric pressure, due perhaps, to the rounded intra-gastric surface of the mass. Thus the combination of the above facts, plus the relative rarity of gastric syphilis, the fact that we thought his syphilitic infection was under control, and that, therefore, a weakened and dilated artery wall was more to be expected than a productive syphilitic lesion, all contributed to our diagnostic pitfall.

Concerning the treatment of the case, I feel



FIG. 2  
X-ray of barium-filled stomach showing filling defect (to readers' left of spine) resulting from growth.



FIG. 3  
X-ray of stomach made 3 months after operation and mixed treatment, showing practically complete disappearance of filling defect. The gastro-enterostomy opening is shown at the lowest point of the stomach.

that the indications for operation were clearly present. Here was a man who was emaciated and starving because of a pyloric obstruction. The obstruction might easily have been from a chronic ulcer or a carcinoma of the pylorus, either of which is just as common in a syphilitic as in one who has not had the disease. The indications were to explore the stomach, prepared to do a resection, a cautery excision, or a simple gastroenterostomy as might be indicated at the time. The findings at operation left only one course open to choice, that of doing an anterior gastroenterostomy. It was technically impossible to do a resection of the growth, had this been advisable. Based upon the gross appearance of the lesion there was little doubt in our minds concerning the nature of the growth.

Another interesting phase of the treatment of this case was the fact that this patient had had thirty to forty injections of either salvarsan or neosalvarsan per year for ten years; that both blood and spinal fluid Wassermanns had been negative for three years; that he had produced a large gumma during this period of Wassermann negativity; and lastly, that the growth disappeared so rapidly and completely under mixed antisyphilitic treatment.

### CONGENITAL BILATERAL ANOPHTHALMOS AND POLYDACTYLISM WITH REPORT OF A CASE\*

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Pensacola.

The presentation of this case is warranted by the unusual physical findings and by the very unusual social question that arose.

In our records here great difficulty was encountered in the differentiation of the terms "microphthalmos" and "anophthalmos." Figuratively one would believe anophthalmos to mean the absolute absence of the eyeballs and microphthalmos, abnormally small eyes. However, some of the later authors have used anophthalmos when there is a rudiment of the globe remaining. May defines anophthalmos as a term used to denote a small solid or cystic mass occupying the place of the eyeball; microphthalmos is defined

\*Read before the Escambia County Medical Society.



by him as an eyeball of diminished size in all diameters. It is not stated whether or not the microphthalmic eye has its function preserved. The older authors have used anophthalmos to indicate the complete absence of the eyeball. Collins and Parsons have stated that it is difficult to tell where to draw the line separating these two conditions, and have laid down the following rule: "When there is complete failure of the essential nervous mechanism of the eyeball, anophthalmos is the proper term; when any of the nervous elements are present, no matter how imperfect, microphthalmos."

It was even suggested that the term, Partial Anophthalmos, be used to indicate that there was not a total absence of the globe.

Therefore, as the author is in no position to controvert the proper terminology for use here in reporting this case, anophthalmos as described by May is preferred, for a small rudimentary bulb was found in the place of the eyeball in each orbital space.

The term polydactylism, meaning supernumerary digits, needs no comment. In perusal of the literature it was found that Collins, of London, has reported a series of thirty cases of bilateral, and twelve of unilateral, anophthalmos. In one of his cases polydactylism occurred also, the infant having six fingers on each hand. There was an elevated spot,  $1\frac{1}{2}$  mm. in diameter, at the posterior pole in a case reported by Wright, while Rosenbaum and others state that there was no evidence of an eyeball in their cases, the optic nerve and its foramina being absent in one instance.

#### REPORT OF CASE

Mrs. R., a primipara aged 29, was admitted to the hospital, having irregular and inefficient pains. The cervix, on rectal examination at 4 p. m. was soft and dilated, but not obliterated. The head was felt in the lower pole; the breech was in the upper pole. Position, left occipito anterior. Presentation, vertex. The foetal heart tones, in the left lower quadrant, were 132 per minute and of good quality. There had been no miscarriages and the prenatal history was negative. Measles in infancy was the only illness the patient ever suffered.

The family history presented nothing of interest. The patient's mother and father are living and well. Two sisters and one brother living and well. There is no history of tuberculosis, carcinomata, renal, mental, or venereal disorders

in the family. The husband is in good health and denies any venereal disease.

The patient, at her request, was allowed to go home, but returned to the hospital at midnight, having severe pains every five minutes, the membranes having ruptured. At one forty a. m. the patient was sent to the delivery room with complete effacement of the cervix. The uterine contractions became weaker and more irregular, and at five a. m. morphine sulphate, grains  $\frac{1}{4}$ , was given to allow the exhausted woman to rest; at seven a. m. the pains became stronger and the baby was delivered normally at nine a. m., the placenta following ten minutes later.

The child was asphyxiated when born and had to be resuscitated. At this time the extra digits were noticed.

It was only when the instillation of silver nitrate was attempted that the astonishing fact of the absence of the eyeballs was revealed. The child was hurried to the nursery without silver nitrate being applied in order that the mother might not become aware of the deformities.

The mother made an uneventful recovery. The breasts were strapped to prevent lactation.

The infant would not nurse. It was fed mother's milk from another mother and artificial food by means of a medicine dropper. The birth weight was six pounds, eight ounces. The baby regurgitated its food and became weaker. Proctoclysis was given with the addition of atrophine. Hypodermoclysis of normal saline was given on the third day, after which the feedings were retained and the child seemed stronger. It progressed steadily until removed from the hospital, but died two days later.

Physical examination of the infant revealed a female, weight, 6 lbs., 8 ozs., normal fontanels, hair and scalp clean. The orbital spaces appeared depressed. The lids were normal and the palpebral conjunctiva appeared normal. Inspection revealed the absence of eyeballs. With lid retractors the conjunctiva was seen to be continued posteriorly for about  $1\frac{1}{4}$  cms., where, at the posterior pole, the rudiment of a bulb was found bilaterally. No cornea or iris could be discerned. The nose showed the lateral cartilages to be pushed medially, giving the appearance of a broad flat nose. The ears had deformed contours, the antihelix being absent. In the mouth lingua frenata was the only deformity. The neck was negative. The thorax had a normal configuration. The heart and



lungs were normal to all forms of examination. Palpation revealed nothing in the abdomen. The anus was present and patent. On the superior extremity there were six digits on each hand, the extra digit being attached by a small pedicle of skin to the skin over the head of the fifth metacarpal bone of either hand. The pedicle was thin and contained no bone. The digit had two phalanges which were completely formed. The sixth toe was well formed on each foot, being attached conjointly with the fifth to the head of the fifth metatarsal bone.

An autopsy was performed, but no pathology other than that described above was found. The optic nerves were present and attached to the rudimentary bulbs. Gonococci were recovered from the orbital cavities both before and after the post mortem examination.

#### ETIOLOGY

Various theories have been advanced as to the etiology of the condition. Rosenbaum states that the most generally accepted theory is that no primary optic vesicle has budded out from the anterior primary encephalic vesicle, or, that having budded out, it has failed to form a secondary

optic vesicle, possibly due to some interference with nutrition.

In only two of the bilateral cases of Collins were the father and mother cousins. In twenty-three out of thirty cases there was no other deformity; in one there was left-sided harelip; in another there was double harelip and six fingers on each side; another had a palatine fissure, deformed skull, and no external opening of the nose. He states that there is neither hereditary influence nor blood relationship of parents found in etiology; supposed maternal impressions were probably coincidences in most cases.

Sex plays no part, as in seventeen cases eight were males and nine were females.

Geiringer and Campuzano state that gonococcal infection of the eyes may occur in utero, the organisms in this instance penetrating into the amniotic fluid, in which case the child is born with a well developed ophthalmia. They further state that cases have been reported in which the eyes were destroyed at birth. This report is important here, as the gonococcus was recovered from the orbital spaces both before and after the post mortem examination.

It is presumed, therefore, that an ophthalmia in utero can occur through the organism pene-



trating into the amniotic fluid causing the deformities presented here, with the exception of the polydactylism.

Although the mother's Wassermann was negative, the possibility of lues must be considered as an etiological factor.

The parents had talked considerably about malformed children. The husband's brother, a physician, was associated with another physician in Chicago (now deceased) who gained great notoriety through his refusal to operate on a malformed child to save its life, and also through newspaper, motion picture, and other means of publicity. It was with him that they talked of the deformities of children on frequent occasions. To those who will consider it, maternal impressions is offered as an additional factor.

Lett, Bell, Raffle, and Atwood and Pond report cases of family polydactylism; extending in one instance through nine generations. There was no history of extra digits in the family of this case.

#### SOCIOLOGICAL ASPECT

The mother was not aware of the maldevelopment of her child until after they had left the hospital. The infant was fed artificially and brought to the mother once daily, the room being darkened on the pretext that light was deleterious to the eyes of the new-born.

The question arose, "shall the child live?" The father and other relatives were bitterly opposed to its existence, demanding that the attendants be negative and allow the child to die. Believing that a life existed and that we had no right, legally, if not morally, to spare any effort to maintain this life as long as it was in the hospital, negative action was refused. Because of this, the mother and baby were removed from the hospital on the eighth day, signing a release to the hospital and attending physicians. The child died two days later.

#### CONCLUSIONS

1. It is difficult to draw a sharp line of demarcation between the terms anophthalmos and microphthalmos.

2. The intrauterine infection with the gonococcus is a possible cause of the development of monstrosities.

3. It is believed that once a life is established no one has a right to directly, or indirectly, take that life.

4. Polydactylism is a more frequent abnormality and occurs in successive generations.

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#### THE MANAGEMENT OF EPILEPSY

WILLIAM S. WALSH, M.D.,

Gainesville.

No physician needs to be told that epilepsy is one of the most distressing of all impairments. Affecting about one of every four hundred people it is recovered from in only a small percentage of cases. It denies the majority of those afflicted the educational, social, and vocational advantages of their normal fellows. And not only does it tend to generate chronic irritability, introspection, dissatisfaction, and other undesirable personality traits which further handicap the individuals and add to their wretchedness, but it leads eventually to physical and mental deterioration.

Were the nature of epilepsy well understood we could, doubtless, radically improve the lot of the unfortunate sufferers from this most serious disease. But though a tremendous amount of work has been, and is still being done, the malady remains almost as mysterious as it was thousands of years ago. Extensive experimental researches have thrown comparatively little light upon it; the same applies to post mortem investigations. In the majority of epileptics we shall, of course, discover on post mortem various developmental defects and other pathological conditions of the nervous system, but there is no common and explanatory pathology, and in most cases the findings appear to be independent of, or concomitants of the disorder.

Parenthetically, it would be more scientific



were we to speak of the epilepsies or of the epileptic syndromes rather than of epilepsy. So-called epilepsy is protean in its expressions, and complex in its basic and precipitating causes; its manifestations are not primary, but are end-results of a variety of pathogenic factors. To many of us the term connotes that form which is markedly motor in character. There are, however, numerous types in which misleading psychic or sensory symptoms predominate. And while consciousness is usually clouded or lost during an attack, it may not be at all affected. One finds this in the Jacksonian form; it is also present in types which correspond to *petit mal* or *grand mal*. It is the rule in myoclonus epilepsy. The latter is comparatively rare. The writer has encountered only one typical case in over a decade of contact with epileptics.

#### CAUSATION

There has been considerable speculation and theory as to the cause of epilepsy. In the present state of our knowledge it is reasonable to believe that an epileptic is an epileptic because his nervous system has a low threshold of resistance or adaptation; that is to say, his nervous system is unstable and hyperirritable and fails to withstand the demands made upon it by reason of physical and mental stresses. Excitations proceeding from these stresses are assimilated or dispersed without difficulty by the normal nervous system, but in certain of the unstable they produce the various reactions which we call epileptic.

The origin of the hyperirritable nervous system is not always explicable. At times it appears to be dependent upon imperfect development of the inhibitory centres, or upon other peculiarities of formation. Injuries during birth or in early life, severe illnesses in childhood, inflammatory conditions of the brain or its adnexa are sometimes culpable. One cannot be certain that such alleged causes are, in all cases, wholly, if at all, etiologic; they may be merely coincidental or they may help to weaken a nervous system which is predisposed to instability. This viewpoint is supported by the fact that many persons who suffer lesions, clinically, identical with those found in epileptics, and which are considered responsible for the epilepsy, do not develop epilepsy; for example, some children who have extensive cerebral hemorrhage and resultant paralysis do not become epileptics.

Heredity is often the scapegoat for many ailments whose genesis is obscure. It is not surprising, therefore, that it has been indicted in connection with epilepsy. In reality it appears to be of minor importance. Our knowledge of human heredity is too incomplete for dogmatic assertions concerning it, and the investigations upon which our statistics are based have been, for the most part, too biased, too superficial, or too unscientific for us to draw sound conclusions from them. It is true that certain familial nervous impairments tend to express themselves as epilepsy, but a person does not inherit epilepsy directly. What one may inherit is an unstable nervous make-up, which instability may reveal itself, under suitable conditions, as mental defect, convulsions for slight causes, psychoses, psychopathies, etc.

The findings of Thom and Walker (*American Journal Psychiatry*, June, 1922) are instructive and indicate that the heredity of epilepsy is not so certain nor so hopeless as we have been led to believe. Of 431 children, resulting from the matings of 117 epileptics, 238 were normal, 14 were feeble-minded, 14 were epileptic, 2 had psychoses, 151 died. According to these writers, if a person predisposed to epilepsy marries a person similarly predisposed, the danger to the tissue is increased; the same holds good in case the person marries one who suffers from alcoholic or luetic poisoning. Maternal defects appear earlier and more often than paternal defects.

An unstable nervous organization is, then, the basis of epilepsy and the feature which all epileptics have in common. But before epilepsy can develop it is necessary that there be some recurrent stimulus which, by direct mechanical excitation or indirectly by inducing chemical or vascular alterations, unduly irritates the nervous system and causes it to bring about the phenomena of epilepsy.

The excitants are apparently numerous; the lack of a constant instigator will account for the failure to discover a specific treatment. There is probably no departure, however transient, from the even tenor of mental and physical performance which may not, in susceptible persons, upset the rhythm of the nervous system and precipitate an epileptic reaction. It is not unlikely that in many subjects the nervous system is, intrinsically or by reason of some artefact, conditioned or sensitized to some particular pathogen; in others the exciting causes are multiple. In

one person an attack may be provoked by gastrointestinal disorders; in another, by periodic chemical changes arising from dyscrinism or an influx of metabolites; in another, by vascular alterations—especially cerebral anemia—dependent upon emotional stress, the hypnagogic state, hypertension, cardio-renal disease; in another, by pressure or irritation from cerebral neoplasms or lesions of the meninges. Such epilepsies are, according to present terminology, secondary or symptomatic. All epilepsies are, in the last analysis, symptomatic; there is a cause for each of them. The essential or idiopathic epilepsies are simply those whose precipitants are unknown.

There is a growing belief among epileptologists that many epilepsies are generated by specific substances, probably products of metabolism. The epileptoid states that occur in diabetes, uremia, eclampsia, and from exogenous poisons render this view tenable. Unfortunately, the identity of these hypothetic toxins remains to be determined. The role of allergy is problematical. About one-third of epileptics are reactors to proteins, but therapy based on this fact has been successful in only a limited number of cases. The possibility of hypersensitiveness to proteins might be borne in mind, however, especially in the convulsive states of young children.

#### DIAGNOSIS

As a rule the epilepsies are recognized without difficulty, especially when frank. They are often confused with many other nervous disorders, chiefly because the physician does not make a thorough examination and because he often makes his diagnosis upon a description of the case; in fact, physical agitation due to emotional crises has been mistaken for epilepsy and has caused some individuals to be committed to institutions. In young persons mild signs of the disease are often overlooked or are attributed to teething, nervousness, constipation, and similar conditions. It is a good plan to be suspicious of epilepsy whenever one encounters any recurrent, "peculiar" disorder involving psychic, motor, or sensory functions, especially in the young.

Hystero-epilepsy is a misnomer. It is possible for a person to have epilepsy and to have hysteria, but both cannot express themselves at the same time; a convulsion, for example, may be either hysterical or epileptic, but it cannot be both. It might be added that many psychical

disturbances, including states of dissociation of the personality, which are ascribed to epilepsy, have hysteria as a basis.

Migraine is sometimes confused with epilepsy, especially *petit mal*. There is apparently some bond between the two disorders. Both have a tendency to "run in families"; one may substitute for the other; for example, a migrainous parent may have an epileptic child; an epileptic parent may have a migrainous offspring. In both there is often a premonition or aura; both have a certain periodicity; both are explosive in character and are precipitated by fatigue, emotional stress, etc.; both tend to be followed by drowsiness. It is a matter of clinical experience that some sufferers from migraine have convulsions during an attack; and that convulsions sometimes replace or alternate with migraine. These convulsions are not, however, essential epilepsy. They are in most, if not in all cases, brought about by vascular changes occurring during an attack of migraine, or which are sequelae of the disease. Migraine is often curable or improvable; it is, therefore, important, both for the present welfare of the sufferer and the prevention of vascular alterations which may lead to epileptoid states, to recognize it early and to institute prompt and proper treatment.

#### THERAPY

When consulted by a patient suspected of having epilepsy it is our duty to consider him as an individual, and as a person who is suffering from a probably curable impairment, not as a person whose case is hopeless and for whom a prescription for bromides is indicated. An investigation of the case from every angle is a prerequisite for successful therapy. The history—including family, developmental, and medical history—will often be a marked assistance; thus, it may reveal whether a familial tendency toward instability exists, or it may point to some definite exciting factor. The fact that relatives have had nervous disorders does not, *per se*, mean that the patient is a victim of a poor heredity. So-called insanity and related disorders may be caused by many things other than heredity.

Explanations offered by the parents are not often valid. Frequently the parents will describe an injury to the head and will call attention to depressions of the skull; indeed, the majority of parents feel that there must be pressure upon the brain, which pressure can be removed by opera-

tion. Most of the alleged injuries are without significance. As to depressions of the skull, as well as to asymmetries and stigmata of various kinds, it is rarely that they cannot be demonstrated, in the subnormal and supernormal, in the normal and abnormal. A history of injury should be carefully investigated, however.

Needless to state, no part of the body should be overlooked in the physical and neurological survey, nor should laboratory tests be neglected. Unfortunately we cannot all make competent examinations, but we can at least make more than a superficial examination, and we can, in case we are suspicious of certain organs, or if we feel that we cannot do justice to the patient, refer the person to specialists.

As a rule, some impairment which is having a definite influence upon the epilepsy will be found in persons who developed the disease after the age of twenty; and in the majority of cases, whatever the age, there can be discovered some habit of life or other correctable condition which is having an untoward effect. Were our examinations more thorough and were we to refer patients to specialists early rather than late, it is safe to say that the number of essential epilepsies would be reduced and recoveries would be more frequent. It is only by proper treatment in the early stages that good results can be had; once the epileptic habit becomes fixed, there are so many added factors which favor the epileptic type of response that they are suppressed with difficulty; indeed, it is usually impossible to suppress them all.

In spite of competent examinations by batteries of experts there will be times when no important excitement can be found. It then becomes a question of what to do for the patient. Under such a condition some physicians have not hesitated to recommend almost any course. For example, some have advised craniotomy; some, ovariectomy; some, colectomy; now that decortication of the carotids has been reported successful in some essential epilepsies, it is likely that this experimental procedure will be widely tried out. It is unwise and unjust to operate on an epileptic without adequate basis. A history of injury to the head is no excuse for a craniotomy; nor is the mother's belief that the menses have something to do with the trouble, sufficient reason for an ovariectomy or hysterectomy. Contrary to popular belief, the female generative organs have little to do with epilepsy. It is true

that structural and functional abnormalities of the generative organs may occasionally incite attacks, but, if so, the seizures will have a definite relation to the menses, or the history or the physical examination will reveal some important gynecologic difficulty.

In these days of enthusiasm over the endocrines it is to be expected that extravagant claims should be made for glandular therapy in the treatment of the epilepsies. There are epilepsies which appear to be influenced by dyscrinism, but they occur infrequently. Often the signs of dyscrinism seen in epileptics are merely reflections of a general mal-development, not indications that the endocrines are causing the epilepsy; we might remember, too, that if dyscrinism were an important genetic factor, epilepsy would be the rule rather than the exception in endocrine disorders. We have so little positive knowledge of the endocrines, and so many of the claims made for substitution therapy require substantiation, that the use of gland products rests on a purely empiric basis, even though evidences of dysfunction exist. Every person—sick or well—conforms to some endocrine type, and if we are myopic enough and extremists enough we shall find few patients who do not appear to be victims of endocrinopathies. Pluriglandular compounds have the same status and are as effective as "gunshot" mixtures in medicine generally. Another point is that, barring thyroid extract, few of the commercial gland preparations are of proven potency when given orally. Thyroid extract is occasionally helpful in epilepsies associated with hypothyroidism, as epilepsies beginning at the menopause, those accompanied by retention of nitrogenous wastes, some cases with obesity, amenorrhea, etc.

There is no specific diet in epilepsy though many have been recommended. Peterman has had good results in many essential epilepsies in childhood with a ketogenic or high fat diet. A rigidly low protein diet is theoretically desirable but is usually ineffective; sometimes it aggravates the attacks. The best diet must be found by a study of the peculiarities of the individual. In general, the food should be well-balanced, well cooked, and well masticated. Meats are permissible in moderation. Naturally, foods which disagree and those which are difficult of digestion should be avoided. Overeating is a common fault in epileptics. Carbonated drinks and large quantities of water at meals tend to be



harmful. Daily evacuations are desirable and should be gained by hygienic means rather than by drugs; constipation does not cause epilepsy, but it does aggravate it in many subjects; it does this partly by reflex impulses resulting from pressure and distension and partly by the absorption of products of putrefaction. The test for excess of indican—an index of putrefaction—is so simple that it might be made routinely; its detection will, by the way, help to clear up the nature of many impairments whose sources are not always apparent, as headache.

Drugs are of value in selected cases; the tendency is to employ them indiscriminately and in large amounts. At best they are palliative; many patients do as well, sometimes better, without them. Even when used, the best results are not likely to obtain unless the life of the individual is modified. It is wise always to prescribe medicine of some kind, if only for the psychic effect. The bromides tend to cause deterioration when taken in large doses over long periods. Luminal, or phenobarbital, appears to be preferable in severe cases; in serial attacks or status it may be given subcutaneously or intravenously. It has an advantage over bromide in that it may be used almost continuously without manifest harm. Some persons have an idiosyncrasy to it; in one case of this kind small amounts of luminal cause marked psychomotor agitation and, if the medication is continued, a condition bordering on mania. When sedatives have been taken over a period of weeks or months, it is imprudent to withdraw them suddenly; otherwise there may occur a serious, if not fatal, increase in the number and severity of the seizures.

Better than medicine or surgery, in the vast majority of essential epilepsies, is a life compatible with the sufferer's low threshold of nervous resistance; namely, a life which will reduce or remove factors which tax his nervous system unduly or which are, in other ways, prejudicial to him. While the program must be individualized, the principal requirements are a well-ordered existence; regularity, especially in eating, sleeping, eliminating; moderate exercise; productive and agreeable occupation; freedom from worry and stress. As to the latter, there are, of course, epileptoid states that are purely psychogenetic and which respond to psychic methods of treatment.

In many cases it is difficult to secure the requisite conditions at home. Again, the home-

living epileptic is likely to be debarred from the schools, to grow up in ignorance and idleness. Usually he is pampered and protected too much; as a result, he becomes inefficient and warped mentally. Epileptics are supposed to be naturally irritable and disagreeable, but there is good reason to believe that their objectionable personality traits are, in many cases at least, due more to faulty training in childhood than to their affliction.

It is advisable, therefore, to encourage such epileptics to take advantage of the provisions made for them in their state institution. In an institution they can receive an education, find suitable employment and recreation, have congenial companions, be freed of many of the stresses of life, and, in addition, obtain medical treatment.

When recommending institutional recourse, let us be frank about the matter. Many epileptics come to institutions believing that they will have unrestrained privileges and will enjoy all the comforts of a sanitarium for the elite. Finding that they have been deceived, they tend to be resentful, and adjust themselves poorly or not at all; further, they lose faith in their advisors. There is no need of deception, no matter what the disorder that makes institutional care prudent. The epileptic are often led to believe also that they will be cured in a few months' time. A promise of cure is always rash; in fact, one cannot say when—if ever—an epileptic is cured, though there is a strong probability of cure if the person has been free of attacks over a period of two or three years, especially without the use of sedatives. One may safely promise improvement for the majority, but years may be necessary to effect it. And just as the tubercular patient cannot afford to ignore the therapeutic principles instilled in him in the sanitarium, so cannot the epileptic patient afford to neglect the factors which led to improvement or apparent recovery. Epilepsy is a stubborn disorder and requires lifelong attention.

If institutions are to do their best they must receive patients before the convulsive habit has become established and before mental and physical degeneration have begun. Epilepsy may be checked, but a mind deteriorated by it can rarely be restored. We should, therefore, encourage the parents to send the sufferer early, in the course of the disease; at this time more can be accomplished and the individual is more plastic

and adjustable. Unfortunately, too many epileptics come to institutions as a last resort, and when recovery or improvement is practically out of the question: if psychometric tests are valid criteria, about seventy-five per cent. of the epileptics sent to institutions are feeble-minded. We might, too, remove the prejudices which many people have toward institutions; and combat other sources of procrastination, as hopes that the child will outgrow his difficulty, or that puberty will bring about some magic change for the better. Hopes such as these are usually hollow, and cause the loss of many valuable years of treatment, and years during which the person's prospects of recovery are in the balance.

#### PREVENTION

Prevention is better than cure. It is safe to say that if we make full use of all the preventives at our disposal we shall effect a marked reduction in the number of future epileptics. No one, probably, has more power in this respect than the general practitioner; it is he who comes into direct and early contact with the potential and the actual epileptic, and depending upon him will depend success in overcoming this grim malady.

From a eugenic aspect it is desirable that persons here literally predisposed to nervous instability, as well as those who show signs of instability, refrain from marriage, especially to persons of like make-up. Our advice here is usually neither appreciated nor wanted, yet we should continue to insist upon the right of every child to be well-born, hoping that eventually an awakened public conscience will take heed.

Adequate care of the prospective mother is essential, not only in lowering the deplorably large number of maternal and infant deaths, but also in reducing the number of children who suffer permanent and incapacitating birth injuries. This consists, in part, in urging the expectant mother to place herself in the hands of a physician early in the course of her pregnancy, and in having a gynecologic examination made well before term so that malposition and other abnormalities, if present, may be corrected.

Birth traumata, especially cerebral hemorrhage, are to be guarded against. Traumata may occur in so-called normal parturitions, but experience shows that they are most common in difficult labors and in labors that have been needlessly terminated by pituitrin and operative pro-

cedures. Delivery by forceps is blamed by timidity for many bad results to mother and child; when indicated, and when performed skillfully, delivery by forceps is without detriment in the majority of cases. Prolonged pressure upon the child's head is probably more conducive to injury. Caruthers has shown that caput succedaneum—which many of us consider unimportant—is almost always associated with edema of the brain and meninges.

A word as to eclampsia. This is an occasional incitant of epilepsy in predisposed individuals; indeed, pregnancy itself may instigate the disorder. Thus, one woman who had eclampsia at the age of fifteen, has averaged two *petit mal* attacks a month for the past fifteen years; another, who had eclampsia at the age of seventeen, has had *grand mal* seizures for the past sixteen years. It is doubtful that eclampsia is a significant factor in producing epilepsy in the offspring. One meets cases now and then in which it is the only apparent cause, but one cannot be certain that it is the real cause. Neugarten in a study of thirty-six children whose mothers had eclampsia found that the eclampsia did not prevent normal development.

Convulsions in infancy and childhood deserve careful consideration. It is true that the infant's nervous system is incoordinate and irritable, but since all young children do not have convulsions because of pyrexia, phimosis, dentition, etc., we are justified in looking upon the convulsions as indications of an epileptic predisposition. To bring a child through an attack of convulsions is not enough; the cause should be sought out, removed if possible, and the parents instructed so that further excitations will be avoided. There is no doubt that convulsions in early life often pave the way for epilepsy. Each convulsion a child has renders the nervous system less stable, and conditions it to an epileptic type of response on slight provocation. In perhaps forty per cent of all epileptics the convulsions began before the tenth year. Follow-up studies of the fate of children who had convulsions reveal that by adult life approximately fifty per cent of them are dead, or are feeble-minded, or are epileptic.

Atypical signs of epilepsy which often are of a fleeting character frequently escape proper evaluation. For example, dreamy and dizzy spells, feelings of fright, blanching of the skin, falls to the floor, staggering, staring, audible inspirations, aimless wandering or running

about, unconscious voiding or biting of the tongue, causeless laughter, munching movements, outcries, peculiar sensations of taste or smell. None of the above is, of course, pathognomonic of epilepsy, but it is well to be suspicious of the disorder when any one or more of them occur, especially when there are recurrent attacks.

All of the children's diseases are important from a preventive standpoint. Pertussis is probably the most serious. This disease is responsible for about 10,000 deaths each year, and for an unknown number of deaths from its sequelae. The writer has seen so many cases of mental defect, epilepsy, and paralysis due, directly or indirectly, to cerebral hemorrhage occurring during paroxysms of coughing that he regards it with concern. Unfortunately there is no preventive vaccine nor any specific medication. We can, however, continue to teach the parents to avoid exposing children to the disease, and we can treat the malady vigorously should it be contracted.

During pertussis, convulsions sometimes arise and add to the seriousness of the disease; in fact, they often cause death. These convulsions are almost always associated with increased reflexes and an increased electrical excitability of the nerves. As shown by Powers, there is a decreased amount of calcium in the blood. The convulsions are therefore related to tetany which, in turn, is dependent upon rickets. Calcium chloride is indicated in these cases. The routine use of cod liver oil and of heliotherapy would do much toward shortening the disease and preventing complications.

Many of the convulsive states in infancy and childhood seen in association with gastro-intestinal disorders, febrile diseases, dentition, etc., also have unsuspected tetany as a basis. While tetany may occur at any age it is often common between the third month and the second year, and in children who have not been fed judiciously. Children of this tendency are usually emotional, quick-tempered, frail, hyperactive. The convulsions differ from the usual convulsions in many ways; for example, the child is restless and does not sleep after them, the larynx is likely to be involved (laryngospasm), consciousness is retained, all reflexes are increased, etc. The presence of Trousseau's and Chvostek's signs will establish the diagnosis.

Finally, a careful observance of the hygiene of

childhood is requisite, especially in children who are neurotic. The object is, of course, to prevent unnecessary excitations and to strengthen the nervous system so that it may be able to withstand the unavoidable stresses of everyday life. Mental hygiene is as imperative as physical hygiene; in fact, there are many of us who assign it first place.

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## JAUNDICE: A CASE REPORT\*

EDWARD JELKS, M.D.,

Jacksonville.

Christmas afternoon, 1925, I spent on a beautiful St. Johns river bluff, seventy miles below Jacksonville. My host was a ruddy complexioned, short, firmly built, and healthy looking man of about fifty-five or sixty years. I followed him up and down bluffs and ravines until I was delighted to hear him say, "I reckon it is about time for us to go back." I carried home the impression that I had met a man of health so good as to indicate many more years of active living.

Imagine my surprise, when about January 10th, I heard he was confined to a hospital in Palatka on account of a serious attack of jaundice. While still at home he had had several courses of calomel and other purgatives with no benefit to the jaundice.

On January 18th he arrived at the Riverside Hospital. His story was that in spite of feeling so well Christmas afternoon, by bedtime he had a vague feeling of biliousness and so took four grs. of calomel. On awakening the morning after Christmas he was definitely jaundiced. This was not accompanied by pain in the abdomen. From other purgatives and "bile tablets" he saw no improvement in the jaundice. On the other hand, it increased steadily until, after seven or ten days, it had developed to its present severity. During this time and subsequently there had been no pain or fever. Were it not for the jaundice, loss of appetite, mild nausea and the feeling of increased weakness, the patient says he would be alright.

In the past he has lived a strenuous, full life. Besides running a combination mercantile and drug store, caring for orange groves, holding the position of a very active member of his church,

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\*Read before the February Staff Meeting of the Riverside Hospital.



and taking a lead in the endeavors of his little town, he has had the unaided duty of rearing his four children since their mother died some fifteen years ago. These activities have not been interfered with by ill health. However, his gastrointestinal history is important. All of his life he has been a hearty eater, in spite of the fact that for the past twenty-five years there have been frequent irregular periods when eating has been followed by upper abdominal distress and belching. Starchy foods have been most liable to cause this. He was troubled most often when under the strain of unusual work. There has been little or no sour stomach. He remembers only two times when he has had definite gastric upsets; the first being a spell of vomiting nine months ago lasting four or five days without abdominal pain or jaundice; the second, an emptying of the stomach by vomiting only once six months ago after he had eaten generously of apple pie. The vomiting did not occur until he had taken a glass of warm water and soda. The more remote history indicates that thirty years ago he had a spell of "brain fog" which forced him to rest for three months. This is not surprising in the light of the knowledge that he comes of a neurotic family; his father committed suicide during a state of mental depression.

Upon entering the room for examination one was impressed at once with the extensive degree of jaundice of the skin and sclerae. It was several shades darker than the yellow paper used to make carbon copies of letters. The icterus index was 232. The patient was comfortable, complained of no soreness or pain, raised up and down with ease and took soft food without difficulty. Though weak, he did not look emaciated. The facies were not anxious. There were no physical findings indicative of cardiac or pulmonary irregularities. The abdominal examination, except for very mild resistance in the epigastrium was negative. There was not the usual tenderness of the gall-bladder region which one finds in disease of the biliary tract. The liver was not enlarged on percussion.

Up to this point in the study, our findings were those of a man fifty-nine years old, the father of four children, with an indefinite gastric history and a sudden appearance three weeks ago of a rapidly developing jaundice. In trying to arrive at a diagnosis the question in our minds was: "Are we dealing with an obstruction of the biliary tract" or, "Are we dealing with a disease

primarily of the liver." If obstruction be the pathology, is this due to stones within the ducts or is it due to a malignant growth pressing upon the biliary tract from without? If the liver itself be the major seat of the trouble is it lues or could this be malignancy of the liver? The past history and Wassermann test were negative for lues. We thought that the duration of the condition and absence of fever could rule out so-called catarrhal jaundice. In an attempt to get more light on the question of biliary obstruction a Lyon's tube was passed into the duodenum. We verified its position by the fluoroscope. No bile was obtained from the various substances used for stimulation.

The gastric analysis was normal except for slight hyperacidity. The stool was clay colored, with only a slight trace of bile. Dr. Beals reported that the X-ray findings indicate thickening of the gall-bladder with probable distention, no shadows of stones, and a constant irregularity of the duodenal bulb, which he thinks is due to an old ulcer. Except for bile and a faint trace of albumin the urine was negative. White blood count was 3,900, red blood count was 3,750,000, hemoglobin was 96% and Wassermann negative.

The laboratory studies, especially the X-ray, brought evidence of obstruction to the biliary tract rather than primary disease of the liver. With the story of insidiously beginning and steadily increasing jaundice, with no pain or fever, in a man of about sixty years old, without a past history of attacks of abdominal pain, we felt we could make the diagnosis of biliary obstruction most likely due to neoplasm probably with metastases to the liver.

In the hope of relieving the obstruction the abdomen was opened on January 27th through an upper right rectus incision. On exposure the gall-bladder, which was covered with adhesions, presented a thick grayish white wall. At its base there could be seen a dark bluish structure about the size of one's thumb, running along the course of the common duct. On aspiration this was found to contain about four ounces of white mucoid substance, "white bile." The examining finger easily passed within this duct towards the duodenum. Just proximal to the ampulla of Vater could be made out a small pouch which contained three small black round stones. When they were removed a clamp was passed easily into the duodenum. A rubber tube was placed upward to the liver and one in the gall-bladder. Examination within the abdomen revealed no

induration or enlargement of the pancreas or glands along the ducts. On the anterior surface of the duodenum about one-half inch from the pylorus was a stellate scar not causing constriction of the duodenum. The patient left the operating table in fair condition. Within the first twenty-four hours about two ounces of mucoid bile stained fluid drained from the tubes. More came from the one which was in the gall-bladder. After this there was practically no further drainage. The patient steadily grew weaker and died on the morning of the 29th about forty-eight hours after his operation. The cause of death certainly was a crippled liver which could not withstand the necessary surgical operation.

We report this case since it brings to our minds phases of the problem of jaundice. (1) In the

first place this is a good lesson of how difficult it is to diagnose with certainty the causes of obstructive jaundice. We surely had very little evidence to substantiate a diagnosis of stones. (2) In the next place it shows the seriousness of operating upon patients with prolonged jaundice. We neglected to say that this man had calcium lactate by mouth and calcium chloride intravenously for several days preoperatively, and also had a blood transfusion twenty-four hours before operation. Thirdly, it places upon us the responsibility of letting patients with increasing jaundice go a long while before operation. I think we can reasonably say that if this man had been operated upon during the first week of his illness, the likelihood is that he would have been restored to good health.

## *Gainesville—Our Convention City*



Masonic Temple



Woman's Club



Infirmary at Florida Farm Colony for Epileptic and Feeble-Minded

This building and its annex contain a modern operating room, an X-ray room, and Laboratory and are equipped to give the best of care to patients.





Infirmary Annex—Florida Farm Colony

Epileptics comprise about 20% of new admissions. A daily record is kept of each epileptic convulsion and usually marked improvement is shown after a few months' treatment.



School Building—Florida Farm Colony

Instruction is given in grade work and in industrial trainingsuch as basketry, weaving and sewing.



## *Gainesville—Our Convention City*

By RAYMOND V. CREDIT

### PART I—THE CITY.

Gainesville has rightly been called the "hub" of Florida. Situated in the north central part of the state it acts as a distributing point for travelers making their way north and south. Three first-class through motor routes enter the city: Number Two, which leads south to Ocala and Plant City and north to High Springs and Lake City; Number Five, which leads to Tampa by the way of Dunnellon and Brooksville; and Number Twelve, which is the short route to Jacksonville. Highway Number Fourteen, a second and third-class road, connects with Palatka and Cross City. The Atlantic Coast Line, Seaboard Air Line, and Tampa and Jacksonville railroads make ingress and egress to and from "The University City" quite easy.

The many oak trees, some of them over eighty feet high and more than four feet in diameter, covered with Spanish moss, do much to give the city an air of stateliness and dignity, and are in harmony with the conservative, substantial growth which Gainesville has enjoyed.

The streets are well-paved with brick and asphalt. Storm sewers adequately take care of all excess surface water. The avenues and streets

are well-lighted. Engineers have said that Gainesville has one of the best and most efficiently operated power plants in the state, in spite of the fact that it is now badly in need of additional equipment to take care of the peak loads.

Tests have proved the water to be exceptionally pure. Coming from a limestone formation, it is practically free from albumen and is low in nitrites and nitrates.

The moral and religious atmosphere of the city is good as can be found anywhere. The leading denominations have attractive places of worship as well as energetic pastors who are ever on the alert to maintain and improve the high moral standards already prevailing.

The population has been estimated to be 12,000 and its citizens are energetic, progressive and hospitable.

It should not be assumed, however, that the people of Gainesville are self-satisfied. Far from it! The recently voted bond issue of \$580,000 is indicative of their progressiveness. This money will be used to build a city hall, enlarge the power plant, purchase equipment for the fire department, lay additional water mains, widen and pave a number of streets, etc.



Ecks' Club—Headquarters for the 53rd Annual Meeting of the Florida Medical Association.

## PART II—THE UNIVERSITY.

The University under the direction of President A. A. Murphree has made rapid progress since his inauguration in 1909. There are thirteen brick buildings on the campus, all of which were provided in the architect's plans at the time of the opening of the University in 1905.

The library, chapel, and basketball court are of recent construction. In 1925 the Legislature appropriated \$525,000 for a two-year building program: \$200,000 for a new science hall, \$125,000 for the first unit of the horticulture building, \$95,000 for the second unit of the engineering building. The remainder of the appropriation is for maintenance and for beautifying the campus.

This year the School of Business Administration and Journalism began functioning with a special faculty of six. A department of architecture has also been created and the future building program will be under its direction.

The increased enrollment which has reached a grand total of 1860 students registered during both semesters has necessitated the addition of new members to the faculties of all the schools and colleges of the University.

Medical men throughout the state will be interested in the work which is being done in the College of Pharmacy under the direction of Dean Townes R. Leigh. The special faculty of this college consisting of four men teaching courses in pharmacy, pharmacognosy, and pharmacology not only have their Ph.D. degrees but have also been licensed to practice pharmacy either in the state of Florida or in the state of their previous residence.

Under the direction of Dr. F. J. Bacon an acre of land is now being devoted to the cultivation of native medicinal plants such as belladonna, hyosyamus, and gelsemium. Efforts are being made to secure twelve acres for this work and some attempt will be made to grow the poppy plant. An illustrated book on the isolation of native principles of plants in Florida is soon to be published. A digest accompanied by illustrations of such plants as horse-mint which produces thymol, and which is found in abundant quantities around Gainesville, will serve as an example of the content of this book.

Dr. Gilfillan and his advanced students are doing research in the making of synthetic drugs. The object of this work is to manufacture synthetic drugs which will accomplish the same



United States Post Office

In its Post Office and other public buildings is reflected the substantial prosperity of Gainesville.



Alachua County Court House

No longer does the old jealousy of Gainesville as the county seat smoulder. This city's tremendous growth makes it the acknowledged metropolis of the Upper Ridge.



First Baptist Church

One of Gainesville's nine white churches where visitors find a warm welcome.





One of the Beautiful Buildings on the University Campus

The University of Florida was the first institution in America to give its Agricultural Department full standing with the other colleges, such as Law, Letters and Medicine.



Public Library



Gainesville's Golf and Country Club

One of the finest golf courses in the State is within easy reach of the city.

results as drugs obtained from plants and at the same time do away with certain disadvantages. A familiar example of what has been done by pharmaceutical chemists along this line is in the synthetic novocaine which accomplishes the same results as cocaine but does not destroy flesh tissues and is non-habit forming. A great many prescriptions used at the University infirmary in large quantities are compounded by the advanced classes in pharmacy.

The Florida State Pharmaceutical Association deserves no little commendation in aiding the College of Pharmacy to make a start. This Association canvassed the druggists of the state and raised \$5,000 to augment the appropriation made by the legislature for this college. Space does not permit us to mention the names of those that have established scholarships and provided awards for exceptional work done by students in the field of pharmacy.

Men of the medical profession have repeatedly asked why a College of Medicine and Surgery has not been established at the University. There is only one answer to their contention that Florida should train its own doctors and surgeons, and that is lack of money! It has been estimated that at least \$5,000,000 would be needed in the first appropriation to put such a college on an efficient operating basis. Even after its establishment there would have to be enormous amounts appropriated in order to adequately take care of salaries, purchase equipment, provide for maintenance, etc. To illustrate: Chicago University would not take over the Rush Medical College until it had \$13,000,000 accumulated for expansion and maintenance. Undoubtedly the day will come when Florida will have a medical school of which it can be proud, but the many other unfinished projects will have to be taken care of first.

In conclusion I am quoting from a letter written by Dean T. J. Bradley of Massachusetts College of Pharmacy, Boston, to Dean Leigh. There is no need for comment—it speaks for itself!

" . . . I have had many contacts with the work of other colleges of pharmacy and I don't remember a new one that has made such rapid progress in so short a time as your school appears to be doing. Evidently, Florida has a great future and you are developing a College of Pharmacy that will be a credit to the state."



*An Invitation  
To Meet Your Fraternity  
While In Gainesville*



The fraternities of the University of Florida invite the members of the medical association who are fraternity men to stay at their respective homes while they are in Gainesville for the medical convention to be held in May. Notify your fraternity of the date of your arrival. The following fraternities extend this invitation to their members:

Pi Kappa Alpha.	Phi Kappa Tau.
Sigma Alpha Epsilon.	Kappa Sigma.
Pi Kappa Phi.	Sigma Nu.
Sigma Phi Epsilon.	Sigma Chi.
Delta Tau Delta.	Kappa Alpha.
Phi Delta Theta.	Theta Chi.
Alpha Tau Omega.	Delta Chi.

Alpha Epsilon (local) invites all Phi Psi's.

# PROGRAM

*of the*

## FIFTY-THIRD ANNUAL MEETING

*of the*

## FLORIDA MEDICAL ASSOCIATION

TO BE HELD AT GAINESVILLE, FLORIDA

MAY 4 and 5, 1926

### INFORMATION

Information desk will be located in the lobby of the Elks Club with continuous service throughout the meeting. All members will be required to register and secure identification badge before attending any of the sessions. Guests and Ladies are requested to register. Tickets for the Banquet, Tuesday, May 4th, may be obtained at the registration desk.

### PROGRAMME OF ENTERTAINMENT

Monday evening, May 3rd, 8 p. m.—Smoker at the Elks Club given by the Alachua County Medical Society.

Tuesday, May 4th, 8 p. m.—Banquet (\$2.50 per plate) at the White House Hotel for the members, their wives and guests. Dance follows Banquet.

### ENTERTAINMENT FOR LADIES

#### *Tuesday, May 4th*

- 9:45 a. m. Chapel exercise at University of Florida Auditorium (conducted by Dr. Hamilton Holt, of Rollins College).
- 11:00 a. m. Bridge and informal gathering with musical followed by luncheon at the Twentieth Century Club House.
- 2:45 p. m. Automobile drive about the city followed by tea at the Club House—Ladies of the Twentieth Century Club, hostesses.
- 5:00 p. m. Dress Parade at University of Florida followed by Organ Recital at the Auditorium by Claude Murphree.
- 8:00 p. m. Banquet at White House Hotel followed by dancing.  
(Cars will be at White House Hotel at 9:45 a. m. and 2:45 p. m. Visiting ladies are requested to meet there.)

#### *Wednesday, May 5th*

- 10:00 a. m. Visit to various buildings of the University of Florida.
- 12:30 a. m. Luncheon at the Episcopal Parish House.

### HOTELS

White House Hotel,	American
Powells Hotel,	European
Arlington Hotel,	American
Graham Hotel,	European
McCormacks Hotel,	European

### COMMERCIAL EXHIBITS

Commercial Exhibits will be located on 1st floor of the Elks Club.

### LOCAL COMMITTEES ON ARRANGEMENTS

J. Maxey Dell, President Alachua County Medical Society, General Chairman.

Banquet: G. C. Tillman, J. L. Summerlin, W. Lassiter, C. L. Pridgeon.

Smoker: J. Maxey Dell, S. D. Rice, J. M. Willis.

Golf: J. L. Summerlin, W. C. Thomas.

Finance: S. D. Rice, M. H. DePass, G. M. Floyd.

### LADIES' COMMITTEE

Mrs. W. Lassiter, Chairman

Mrs. G. C. Tillman	Mrs. S. D. Rice
Mrs. M. H. DePass	Mrs. J. H. Hodges
Mrs. D. T. Smith	Mrs. W. C. Thomas
Mrs. J. H. Colson	Mrs. N. W. Sanborn
Mrs. J. L. Summerlin	

### TUESDAY MORNING SESSION, 9 O'CLOCK

Call to order by J. Maxey Dell, Gainesville, Chairman of Committee on Arrangements.

Opening Prayer, Rev. John R. Cunningham.

Address of Welcome, Dr. A. A. Murphree, President University of Florida.

Response, J. D. Love.

Announcements.

Address of President, John S. McEwan, Orlando.

### SCIENTIFIC ASSEMBLY

Committee on Scientific Work: Frederick J. Waas, Chairman; John S. Helms, M. A. Lischkoff.

Stenographer: Mrs. Lucille Jones, Jacksonville.

Attention is called to the following By-Laws:

"All papers read before the Society shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orators, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, nor more than once on any one subject."

1. Cholecystography, Its Interpretation, with Lantern Slide Demonstration.

L. W. CUNNINGHAM, in collaboration with JOHN E. BOYD and W. McL. SHAW, Jacksonville.

Discussion opened by JOHN S. HELMS, Tampa, G. RAAP, Miami.

2. Some Problems in Neurological Surgery.

CHARLES EDWARD DOWMAN, Atlanta, Georgia (by invitation).

3. An Analysis of Fifty Cases Showing a Basal Metabolism Rate Under Fifteen Per Cent Below Average Normal.

E. W. BITZER, Tampa.

Discussion opened by HORACE DREW, Jacksonville, G. C. TILLMAN, Gainesville.

## GENERAL MEETING OF THE ASSOCIATION

MAY 4, 12:15 P. M.

The President in the Chair.

Report of Officers.

Secretary-Editor and Treasurer, Shaler Richardson.

Executive Committee, J. D. Love.

Committee on Legislative and Public Policy, Ernest B. Milam.

Councillors:

FIRST DISTRICT—Dr. W. C. Payne.....*Pensacola*  
Okaloosa, Walton, Santa Rosa, Escambia.SECOND DISTRICT—Dr. J. C. Davis.....*Quincy*  
Liberty, Gadsden, Jefferson, Wakulla, Leon.THIRD DISTRICT—Dr. R. B. Harkness  
(Chairman) .....*Lake City*  
Hamilton, Dixie, Taylor, Madison, Columbia,  
Suwannee, Lafayette.FOURTH DISTRICT—Dr. R. B. McIver  
(Secretary) .....*Jacksonville*  
Nassau, Clay, Duval, St. Johns.FIFTH DISTRICT—Dr. H. C. Dozier.....*Ocala*  
Citrus, Hernando, Marion.SIXTH DISTRICT—Dr. C. A. Williams.....*St. Petersburg*  
Pasco, Pinellas.SEVENTH DISTRICT—Dr. M. E. Heck.....*DeLand*  
Brevard, Volusia, Seminole.EIGHTH DISTRICT—Dr. J. M. Dell.....*Gainesville*  
Putnam, Levy, Baker, Bradford, Union, Flagler,  
Alachua.NINTH DISTRICT—Dr. W. J. Blackshear....*Panama City*  
Holmes, Washington, Bay.TENTH DISTRICT—Dr. R. L. Kline.....*Lakeland*  
Polk.ELEVENTH DISTRICT—Dr. J. A. Simmons.....*Miami*  
Dade.TWELFTH DISTRICT—Dr. Baker Whisnant....*Fort Myers*  
Glades, Charlotte, Hendry, Lee, Collier.THIRTEENTH DISTRICT—Dr. J. B. Wallace.....*Tampa*  
Hillsborough.FOURTEENTH DISTRICT—Dr. N. A. Baltzell....*Marianna*  
Calhoun, Jackson, Gulf.FIFTEENTH DISTRICT—Dr. L. A. Peek.....*West Palm Beach*  
Palm Beach, Broward.SIXTEENTH DISTRICT—Dr. M. M. Hanum.....*Eustis*  
Sumter, Lake.SEVENTEENTH DISTRICT—Dr. G. H. Edwards....*Orlando*  
Osceola, Orange.EIGHTEENTH DISTRICT—Dr. Jack Halton.....*Sarasota*  
Manatee, Sarasota.NINETEENTH DISTRICT—Dr. D. L. McSwain....*Arcadia*  
DeSoto, Hardee, Highlands.TWENTIETH DISTRICT—Dr. Wm. R. Warren....*Key West*  
Monroe.TWENTY-FIRST DISTRICT—Dr. H. D. Clark....*Ft. Pierce*  
St. Lucie, Okeechobee, Indian River, Martin.

## SCIENTIFIC ASSEMBLY

MAY 4, 2 P. M.

4. Eczema, In Infancy and Childhood.

WILLIAM EWING SINCLAIR, Orlando.

Discussion opened by N. L. SPENGLER, Tampa,  
THOMAS E. BUCKMAN, Jacksonville.

5. A Plea for More Judgment in Correcting Uterine Displacements.

J. S. TURBERVILLE, Century.

Discussion opened by W. M. ROWLETT, Tampa,  
G. E. EDWARDS, Orlando.

6. The State Board of Health, Its Anatomy and Physiology.

B. L. ARMS, State Health Officer.

7. Some Observations on Chronic Gall Bladder Diseases.

J. KNOX SIMPSON, Jacksonville.

Discussion opened by W. C. PAYNE, Pensacola,  
STANLEY ERWIN, Jacksonville.

8. Surgical Treatment of Goitre.

LEROY A. WYLIE, St. Petersburg.

Discussion opened by H. C. DOZIER, Ocala, H. A.  
PEYTON, Jacksonville.

9. The Outlook in Diabetic Children.

LOUIE LIMBAUGH, Jacksonville.

Discussion opened by J. H. FELLOWS, Pensacola,  
W. C. THOMAS, Gainesville.

10. Mercurochrome in the Treatment of Septicaemia of Mastoid Origin.

T. H. ODENEAL, West Palm Beach.

Discussion opened by H. M. TAYLOR, Jacksonville,  
J. BROWN FARRIOR, Tampa.

11. Fractures of the Femoral Shaft Treated by Traction.

F. L. FORT, Jacksonville.

Discussion opened by DONALD BABCOCK, Miami,  
EDWARD JELKS, Jacksonville.

## MEETING OF THE HOUSE OF DELEGATES

5 P. M.

## SCIENTIFIC ASSEMBLY

MAY 5, 9:00 A. M.

12. Bronchial Asthma and Its Relation to Sinus Disease in Children.

M. A. LISCHKOFF and J. H. FELLOWS, Pensacola.  
Discussion opened by A. H. FREEMAN, Ocala, F.  
CLIFTON MOOR, Tallahassee.

13. Lead Poisoning in Children.

LUTHER W. HOLLOWAY, Jacksonville.

Discussion opened by G. S. OSINCEP, Orlando,  
W. W. KIRK, Jacksonville.

14. The Estimation of Heart Reserve.

JULIAN E. GAMMON, Jacksonville.

Discussion opened by M. J. FLIPSIE, Miami, H. H.  
HARRIS, Jacksonville.

15. Labor, Normal and Abnormal.

S. R. NORRIS, Jacksonville.

Discussion opened by T. S. FIELD, Jacksonville,  
A. M. AMES, Pensacola.

16. Early Diagnosis of Tuberculosis.

W. A. CLAXTON, District Medical Officer, Miami,  
State Board of Health.Discussion opened by R. H. MCGINNIS, Jackson-  
ville, T. Z. CASON, Jacksonville.17. Some Pre-operative Factors Influencing the Mortali-  
ty of Prostatectomy.

JOHN E. HALL, West Palm Beach.

Discussion opened by E. S. GILMER, Tampa,  
ROBERT MCIVER, Jacksonville.

18. Additional Scraps from Memory's Storehouse of Sanitary Doings in Florida During the Past Half Century.

JOSEPH Y. PORTER, Key West.



## GENERAL MEETING OF THE ASSOCIATION

MAY 5, 12:00 NOON

The President in the Chair.  
Annual Election of Officers.  
Adjournment for Lunch.

## SCIENTIFIC ASSEMBLY

MAY 5, 2 P. M.

19. The Causes of Insanity.  
W. H. SPIERS, Orlando.  
Discussion opened by B. F. BARNES, Chattahoochee, G. H. BENTON, Miami.
20. Squint—The Cooperation of the General Profession and the Ophthalmologist in the Treatment of Same.  
HEWETT JOHNSTON, Orlando.  
Discussion opened by RALPH D. MURPHY, St. Petersburg, SHALER RICHARDSON, Jacksonville.
21. Report of Cases. Conditions Following Urethral Stricture.  
EDMUND H. TEETER, Jacksonville.  
Discussion opened by B. F. WOOLSEY, Jacksonville, A. L. MILLS, St. Petersburg.
22. Neurological Signs of Disease of the Hypophysis Cerebri.  
TOM A. WILLIAMS, Miami Beach.  
Discussion opened by RALPH GREENE, Jacksonville, H. MASON SMITH, Tampa.
23. Pyelitis Complicating Pregnancy.  
I. M. HAY, St. Augustine.  
Discussion opened by C. D. ROLLINS, Jacksonville, A. D. STOLLENWERCK, Jacksonville.
24. Nasal Ganglion Phenomena.  
HIRAM BYRD, Bradenton.  
Discussion opened by W. C. BRYAN, Bradenton, A. O. MORTON, Sarasota.

## OFFICERS

## OFFICERS OF THE FLORIDA MEDICAL ASSOCIATION

JOHN S. McEWAN, M.D., President.....Orlando  
H. MASON SMITH, M.D., First Vice-President....Tampa  
CARL WILLIAMS, M.D., Second Vice-President.....St. Petersburg  
JOHN A. SIMMONS, M.D., Third Vice-President...Miami  
SHALER RICHARDSON, M.D., Secretary-Treasurer.....Jacksonville  
STEWART G. THOMPSON, Business Manager..Jacksonville

## EXECUTIVE COMMITTEE

JAMES D. LOVE, M.D., Chairman.....Jacksonville  
G. H. EDWARDS, M.D.....Orlando  
JOSEPH HALTON, M.D.....Sarasota

## COMMITTEE ON SCIENTIFIC PROGRAM

FREDERICK J. WAAS, M.D., Chairman.....Jacksonville  
JOHN S. HELMS, M.D.....Tampa  
M. A. LISHKOFF, M.D.....Pensacola

## COMMITTEE ON LEGISLATION AND PUBLIC POLICY

ERNEST B. MILAM, M.D., Chairman.....Jacksonville  
W. M. ROWLETT, M.D.....Tampa  
L. M. ANDERSON, M.D.....Lake City  
CLIFTON MOOR, M.D.....Tallahassee  
E. W. WARREN, M.D.....Palatka  
W. J. CALVIN, M.D.....Eustis

## DISTRICTS OF THE FLORIDA MEDICAL ASSOCIATION AND COUNCILLORS

- FIRST DISTRICT—Dr. W. C. Payne.....Pensacola  
Okaloosa, Walton, Santa Rosa, Escambia.
- SECOND DISTRICT—Dr. J. C. Davis.....Quincy  
Liberty, Gadsden, Jefferson, Wakulla, Leon.
- THIRD DISTRICT—Dr. R. B. Harkness  
(Chairman).....Lake City  
Hamilton, Dixie, Taylor, Madison, Columbia, Suwannee, Lafayette.
- FOURTH DISTRICT—Dr. R. B. McIver.  
(Secretary).....Jacksonville  
Nassau, Clay, Duval, St. Johns.
- FIFTH DISTRICT—Dr. H. C. Dozier.....Ocala  
Citrus, Hernando, Marion.
- SIXTH DISTRICT—Dr. C. A. Williams.....St. Petersburg  
Pasco, Pinellas.
- SEVENTH DISTRICT—Dr. M. E. Heck.....DeLand  
Brevard, Volusia, Seminole.
- EIGHTH DISTRICT—Dr. J. M. Dell.....Gainesville  
Putnam, Levy, Baker, Bradford, Union, Flagler, Alachua.
- NINTH DISTRICT—Dr. W. J. Blackshear....Panama City  
Holmes, Washington, Bay.
- TENTH DISTRICT—Dr. R. L. Kline.....Lakeland  
Polk.
- ELEVENTH DISTRICT—Dr. J. A. Simmons.....Miami  
Dade.
- TWELFTH DISTRICT—Dr. Baker Whisnant....Fort Myers  
Glades, Charlotte, Hendry, Lee, Collier.
- THIRTEENTH DISTRICT—Dr. J. B. Wallace.....Tampa  
Hillsborough.
- FOURTEENTH DISTRICT—Dr. N. A. Baltzell....Marianna  
Calhoun, Jackson, Gulf.
- FIFTEENTH DISTRICT—Dr. L. A. Peek....West Palm Beach  
Palm Beach, Broward.
- SIXTEENTH DISTRICT—Dr. M. M. Hanum.....Eustis  
Sumter, Lake.
- SEVENTEENTH DISTRICT—Dr. G. H. Edwards....Orlando  
Osceola, Orange.
- EIGHTEENTH DISTRICT—Dr. Jack Halton.....Sarasota  
Manatee, Sarasota.
- NINETEENTH DISTRICT—Dr. D. L. McSwain....Arcadia  
DeSoto, Hardee, Highlands.
- TWENTIETH DISTRICT—Dr. Wm. R. Warren....Key West  
Monroe.
- TWENTY-FIRST DISTRICT—Dr. H. D. Clark....Ft. Pierce  
St. Lucie, Okeechobee, Indian River, Martin.

## STAFF OF THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

## EDITOR

Shaler Richardson, M.D.

## BUSINESS MANAGER

Stewart G. Thompson, D. P. H.

## ASSOCIATE EDITORS

Robert B. McIver, M.D.....Jacksonville  
T. A. Neal, M. D. ....Orlando  
J. B. Wallace, M.D. ....Tampa  
R. O. Lyell, M.D. ....Miami  
M. A. Lischkoff, M.D.....Pensacola  
Ralph N. Greene, M.D. ....Jacksonville

The Annual Meeting of the Florida Railway Surgeons' Association will be held in Gainesville Monday, May 3rd. The program will be announced later.

## CONCERNING THE CHANGES IN THE CONSTITUTION AND BY-LAWS

The March, 1926, issue of THE JOURNAL contains the proposed Constitution and By-Laws for the Florida Medical Association, submitted at the St. Petersburg meeting in 1925, to be voted on by the House of Delegates at the Gainesville meeting, May 3-4-5, 1926.

In order that the Delegates may have an opportunity to study and compare this proposed measure with the Constitution and By-Laws under which the Association is operating at present, and adopted at the Orlando meeting in 1924, THE JOURNAL is publishing the latter in this issue.

Not a great number of physicians have the time to study the requirements of a Constitution and By-Laws, but when many issues are involved in a change of policy, it is expedient and necessary that Delegates inform themselves thoroughly on the qualifications and practicability of the change.

It is urged that Delegates to the meeting at Gainesville will be so prepared by a comparison of the two Constitutions and By-Laws, to vote on this matter intelligently and with dispatch that no time be wasted on debate and discussion.

The following is the present Constitution and By-Laws:

## CONSTITUTION AND BY-LAWS OF THE FLORIDA MEDICAL ASSOCIATION

### ARTICLE I.

#### *Name of the Association*

The name and title of this organization shall be the Florida Medical Association.

### ARTICLE II.

#### *Purposes of the Association*

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar Associations in other States to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material in-

terests; and to the enlightenment and direction of public opinion in regard to the great problems of State medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

### ARTICLE III.

#### *Component Societies*

Component Societies shall consist of those county medical societies which hold charters from this Association.

### ARTICLE IV.

#### *Composition of the Association*

Section 1. This Association shall consist of Members, Delegates and Guests.

Sec. 2. *Members*—The members of this Association shall be the members of the component county medical societies.

Sec. 3. *Delegates*—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

Sec. 4. *Guests*—Any distinguished physician not a resident of this State may become a guest during any Annual Session upon invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that Session.

### ARTICLE V.

#### *House of Delegates*

The House of Delegates shall be the legislative and business body of the Association, and shall consist of (1) Delegates elected by the component county societies, and (2), *ex-officio*, the officers of the Association as defined in this Constitution.

### ARTICLE VI.

#### *Sessions and Meetings*

Section 1. The Association shall hold an Annual Session, during which there shall be held daily not less than two General Meetings, which shall be open to all registered members, delegates and guests.

Sec. 2. The place for holding each annual session shall be fixed by the House of Delegates, the time to be determined by the Executive Committee at a date not later than four months prior to the annual meeting.

## ARTICLE VII.

*Officers*

Section 1. The officers of this Association are to be a President, three Vice-Presidents, a Secretary and Treasurer, Editor of THE JOURNAL, Executive Committee, and fourteen Councillors. In the discretion of the Association, the offices of Secretary, Treasurer and Editor of THE JOURNAL may be held by one individual.

Sec. 2. All officers are to be elected annually, and shall serve until their successors are elected and installed.

Sec. 3. The officers of this Association shall be elected by the Association at noon on the second day of the annual session, and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such an office who is not in attendance during that annual session (except the Councillors) and who has not been a member of the Association for two years.

Sec. 4. THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION shall be the official organ of the Association.

## ARTICLE VII (a)

Funds for meeting expenses of the Association are to be arranged for by the House of Delegates, by an equal per capita assessment on each county society to be fixed by the House of Delegates, or by voluntary contributions or bequests, and by profits of publications. Funds may be provided by the House of Delegates to defray the expenses of the annual sessions, for publications, and for such other purposes as may be proper in the discretion of the Association.

## ARTICLE VIII.

*Referendum*

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members, or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question, and be binding upon the House of Delegates.

## ARTICLE IX.

*The Seal*

The Association shall have a common Seal,

with power to break, change or renew the same at pleasure.

## ARTICLE X.

*Amendments*

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

## BY-LAWS.

## CHAPTER I.

*Membership*

Section 1. All members of Component Societies shall be privileged to attend all meetings and take part in all of the proceedings of the Annual Session, and shall be eligible to any office within the gift of the Association.

Sec. 2. The name of a physician upon the properly certified roster of members, or list of delegates, of a component society which has paid its annual assessment, shall be *prima facie* evidence of his right to register at the annual session in the respective bodies of this Association.

Sec. 3. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take any part in any of its proceedings until such time as he has been relieved of such disability.

Sec. 4. Each member in attendance at the annual session shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.

## CHAPTER II.

*Annual and Special Sessions of the Association*

Section 1. The Association shall hold an an-



nual session at such time and place as has been fixed at the preceding annual session.

Sec. 2. Special sessions of either the Association or House of Delegates may be called by the President.

### CHAPTER III.

#### *General Meetings*

Section 1. The General Meetings shall include all registered members, delegates and guests, who shall have equal rights to participate in the proceedings and discussions, and, except guests, to vote on pending questions. Each General Meeting shall be presided over by the President, or in his absence or disability, or by his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President and the annual orations, and the entire time of the Session so far as may be shall be devoted to papers and discussions relating to scientific medicine.

Sec. 2. The General Meeting shall have authority to create committees or commissions for scientific investigations of special interest and importance to the profession and public, and to receive and dispose of reports of the same; but any expense in connection therewith must first be approved of by the House of Delegates.

Sec. 3. Except by special vote, the order of exercises, papers and discussions as set forth in the official program shall be followed from day to day until it has been completed.

Sec. 4. No address or paper before the Association, except those of the President and Orators, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, nor more than once on any one subject.

Sec. 5. All papers read before the Society shall be its property. Each paper shall be deposited with the Secretary when read.

### CHAPTER IV.

#### *House of Delegates*

Section 1. The House of Delegates shall meet annually at the time and place of the annual session of the Association, and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President and the annual oration, and so as to give delegates an opportunity to attend the other scien-

tific proceedings and discussions so far as is consistent with their duties. But if the business interests of the Association and profession require, it may meet in advance, or remain in session after the final adjournment of the General Meeting.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every 20 members, and one for each major fraction thereof, but each county society holding a charter from this Association, which has made its annual report and paid its assessment as provided in this Constitution and By-Laws, shall be entitled to one delegate. Provided, that this annual report must be made to the Secretary of the State Association at least thirty days prior to the date of the annual meeting.

Sec. 3. A majority of the registered delegates shall constitute a quorum, and all of the meetings of the House of Delegates shall be open to members of the Association.

Sec. 4. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county of the State who can be made reputable has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate work in medical centers, as well as home study and research, and shall endeavor to have the

results utilized and intelligently discussed in the county societies.

Sec. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body in such a manner that not more than one-half of the delegates shall be elected in any one year.

Sec. 8 (a). It shall, upon application, provide and issue Charters to County Societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 9. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies, and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 10. It shall divide the State into Councillor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of competent county societies, and no other, shall be members in such district societies. When so organized, from the presidents of such district societies shall be chosen the Vice-Presidents of this Association, and the presidents of the county societies of the district shall be the vice-presidents of such district societies.

Sec. 11. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates, and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Sec. 12. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 13. It shall publish its proceedings in the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION.

#### CHAPTER V.

##### *Election of Officers*

Section 1. All elections shall be by secret ballot, unless there is but one nominee for an office

when the Secretary, upon motion duly seconded and carried, is empowered to cast the ballot of the Association for the nominee. A majority of the votes cast shall be necessary to elect.

#### CHAPTER VI.

##### *Duties of Officers*

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged; shall give a deciding vote in case of a tie, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the State and assist the Councillors in building up the county societies, and in making their work more practical and useful.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties, and in the event of his death, resignation or removal, shall succeed him.

Sec. 3. The Treasurer shall give bond in the amount of his yearly budget. He shall demand and receive all funds due the Association, together with bequests and donations, and shall have the care and arrangement of the fiscal affairs of the Association. He shall subject his accounts yearly to audit by a Certified Public Accountant, and render an annual report of his doings to the first general meeting of the Association. He shall charge upon his books the assessments upon each Component County Society at the end of the fiscal year, which assessments he shall collect and make the proper credits for, and he shall perform such other duties as may be assigned to him. All funds belonging to the Association shall be deposited in a National Bank to the credit of the Association, and all funds belonging to THE JOURNAL shall likewise be deposited in a National Bank to the credit of THE JOURNAL. No money shall be drawn from either account except by proper voucher checks, serially numbered. The expenses of the Treasurer's bond, and audit of accounts, shall be paid by the Association.

Sec. 4. The Secretary shall attend all meetings of the Association and of the House of Delegates, and shall keep minutes of their respective

proceedings in special record books. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the Annual Sessions. He shall keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power he shall use the printed matter, correspondence and influences of his office to aid the Councillors in the organization and improvement of the county societies, and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the first general meeting of the Association. In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be \$600.00 per annum.

#### CHAPTER VII. *Council*

Section 1. The Executive Committee shall consist of the President and Secretary, *ex officio*, and three members to be appointed by the President. It shall consider and act upon all matters of business pertaining to the Association in the interval between the annual sessions, and shall render a report of its actions to the General Meetings.

Sec. 1. The Council shall hold daily meetings during the annual sessions of the Association and at such other times as necessity shall require, subject to the call of the Chairman. It shall annually elect a Chairman and a Secretary, and the latter shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the first annual meeting of the Association.

Sec. 2. Each Councillor shall be organizer, peace-maker and censor for his district. He shall

visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each annual session of the Council. The necessary traveling expenses incurred by such Councillor in the line of the duties herein imposed may be allowed by the Council upon a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Association.

Sec. 3. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates, or the general meeting, must originate in the county society and shall be referred to the Council without discussion.

#### CHAPTER VIII. *Committees*

Section 1. Regular Committees shall be the Executive Committee, a Committee on Legislation and Public Policy, and a Committee on Scientific Work. They shall be appointed by the President.

Sec. 2. The Committee on Scientific Work shall consist of three members, and it shall determine the character and scope of the Scientific proceedings of the Association, subject to the provisions in the Constitution and By-Laws. It shall prepare and issue a program for each annual session announcing the order in which papers, discussions, and other business shall be presented. The number of papers to be read before each annual session shall be left to the discretion of the Committee on Scientific Work, and that no member be permitted to present a paper in successive years.

Sec. 3. The Committee on Legislation and Public Policy shall consist of three members and the President and Secretary. Under the direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of the public health and of scientific medicine. It shall keep in touch with



professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall utilize every organized influence of the profession to promote the general influence in local, state and national affairs and elections. Its work shall be done with the dignity becoming a great profession and with that wisdom which will make effective its powers and influence. It shall have authority to be heard before the entire Association upon questions of great concern at such time as may be arranged during the annual session.

Sec. 4. The Committee on Publication shall consist of the Editor and two others to be appointed by the President, and shall have referred to it all reports on scientific subjects and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication may be returned to the author. All papers read before the Association shall be the property of the Association. The Editor shall receive an annual salary of \$600.00, provided that this be paid out of the funds of THE JOURNAL.

Sec. 5. The Committee on Arrangements shall consist of the component society in the territory in which the annual session is to be held. It shall, by committees of its own selection, provide suitable accommodations for the meeting-places of the Association and of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall make additional announcements during the session as occasion may require.

#### CHAPTER IX.

##### *Assessments and Expenditures*

Section 1. An assessment of \$5.00 per capita on the membership of the component societies is hereby made the annual dues of the Association, of this amount \$3.00 shall be set aside as a subscription for THE JOURNAL. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association thirty days in advance of each Annual Session.

Sec. 2. Any county society which fails to pay its assessment, or make the reports required, on or before the date above stated, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 3. All motions or resolutions appropriating money shall specify a definite amount, or so much thereof as may be necessary for the purpose indicated, and must be approved by the Council and House of Delegates on a call of the ayes and noes.

Sec. 4. Any county society shall have authority to remit the dues of its Secretary, to the State Association, for duties performed in accordance with the Constitution and By-Laws.

#### CHAPTER X.

##### *Rules of Conduct*

The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

#### CHAPTER XI.

##### *Rules of Order*

The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts' Rules of Order, unless otherwise determined by a vote of its respective bodies.

#### CHAPTER XII.

##### *County Societies*

Section 1. All county societies now in affiliation with this Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, upon application to the Council, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.

Sec. 3. Charters shall be issued only upon approval of the Council or House of Delegates and shall be signed by the President and Secretary of this Association. The Council or House of Delegates shall have authority to revoke the

charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councillor for the District if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable white and legally registered physician who is practicing, or who will agree to practice, non-sectarian medicine shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right of appeal to the Executive Committee, which, upon a majority vote, may permit him to become a member of an adjacent county society.

Sec. 7. In hearing appeals the Executive Committee may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councillors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component society moves to another county in this State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Sec. 10. Each county society shall have general direction of the affairs of the profession

in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official position and other preferments shall be unstintingly given to such members.

Sec. 12. At the time of the annual election of officers each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each twenty members or fraction thereof, and the secretary of the society shall send a list of such delegates to the Secretary of this Association, at least ten days before the annual sessions.

Sec. 13. The Secretary of each county society shall keep a roster of its members, and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, thirty days in advance of each annual session, and at the same time that the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

## CHAPTER XIII.

### *Amendments*

These By-Laws may be amended at any annual session by a majority vote of all the delegates present at that session, after the amendment has laid upon the table for one day.

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TWENTY-FIRST DISTRICT—DR. H. D. CLARK . . . . . Ft. Pierce  
St. Lucie, Okeechobee, Indian River, Martin.

cine. The general practitioner learns the specialist's viewpoint and vice versa. Planned discussions of all papers have been in evidence during the past few years of our association meetings. These are augmented by impromptu discussions.

The entertainment program is quite elaborate and aimed primarily at stimulating a closer relationship between the entire membership. The local committee of the Alachua County Medical Society is very desirous of affording the membership an opportunity to visit the State University and learn of its workings. At all times our members should manifest a keen interest in the University and during the meeting the opportunity of visiting the University of Florida should not be overlooked.

Good roads enter Gainesville from every section of the state and it is expected that most of

## THE GAINESVILLE MEETING

This issue of THE JOURNAL contains the program for the annual meeting of the Association to be held in Gainesville, May 3-4-5. The Scientific papers cover a varied list of subjects, all phases of medicine and surgery being represented. The Florida Medical Association has not reached that unwieldy size that necessitates its scientific programs being sectioned. This is indeed fortunate for one, be he general practitioner or specialist, may attend the entire program and enrich his general knowledge of medi-



those attending the meeting will come by motor. Ample provision for automobile accommodations is being planned by the local committee. Hotel accommodations are sufficient to take care of a record-breaking attendance.

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### SMALLPOX

During the recent smallpox outbreak in certain sections of the state the lay press has been loathe to publish some of the facts pertinent thereto. For this reason many of our citizens have neglected the precaution of vaccination, not realizing the conditions that actually existed. It is understood that the publication of the number of cases existing in certain communities was not deemed fit reading matter for the public mind by certain newspapers, and it was only by coercion on the part of the State Health authorities that the press yielded to the wishes of the State Board of Health. Florida's prosperity could certainly be materially affected by an epidemic of smallpox. This is only to be avoided by making known to the public through the press the number of cases existing in each community and by broadcasting vaccination propaganda.

Occasionally a medical editor finds a lay periodical handling a medical subject in such a commendable way that he wishes to applaud. March 27 issue of the *Saturday Evening Post* contains a most enlightening editorial entitled "Do We Want More Smallpox?" The general prevalence of smallpox over the entire United States is the reason for this editorial which is an appeal for vaccination and the enforcement of vaccination legislation. The lay press of our state will do well to bring before their readers in as lucid a way as the *Saturday Evening Post* has the matter of smallpox increase and the need for vaccination. Let the lay press of our state realize that the promulgation of facts concerning the outbreak of smallpox and an appeal for vaccination are the greatest factors for bringing about a state population with an immunity to this loathsome disease.

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### THE ANNUAL BANQUET

For some years it has been the custom for the County Medical Society at the place of meeting of the annual association convention to act as host at a banquet for all the members in attendance. At times this has worked somewhat of a hardship on the smaller county medical societies.

Recently the Executive Committee of the State Association took up this matter and decided that this precedent should be done away with. It is a well-known fact that most of the state and national medical associations hold annual banquets at their meetings and charge each guest for attending. Beginning this year, each member will be asked to purchase for himself and guests, tickets covering the banquet charge.

The Executive Committee wishes the members of the association to know that the Alachua County Medical Society was very desirous of acting as banquet host during our coming meeting. However, the Executive Committee deemed it advisable to inaugurate the custom of purchasing banquet tickets during the present year.

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### MEMBERSHIP

Just prior to each annual meeting interest is aroused in the Association's increase in membership. During the past year, however, this interest has been alive in certain quarters during the entire year. Our President has been alert to every opportunity to bring eligible doctors into the folds of organized medicine. He has personally assisted in the organization of several new societies and as a result we have organized new societies in Lee and Broward Counties.

Let each county society review the list of eligibles outside their organization and set about to bring them into the State Association. The Florida Medical Association should boast of over one thousand members by the end of the present year.

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### NEWS ITEMS

The first Infant Welfare Station in Florida was opened in Jacksonville Wednesday, March third. It is the plan of the City Health Officer, Dr. N. A. Upchurch, to maintain several such stations in the city, and to conduct the work along the lines of preventive pediatrics, as is done in the cities of the East. The Infant Welfare Work in Jacksonville is in charge of Dr. Thomas E. Buckman.

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Mr. Carey Hand, mortician of Orlando, Florida, is now equipped to cremate the remains of deceased when requested. This venture of Mr. Hand's is significant of the progress being made in this State. The first body was cremated about

the middle of March and from the reports, the work was very satisfactory. Mr. Hand stated recently that any work entrusted to him would be handled in a sacred manner.

The Editor has made some inquiry as to the nearest crematory, and has been advised that Washington, D. C., or Cincinnati, Ohio, has the nearest crematory to the one that has just been opened at Orlando.

Concerning the smallpox situation the State Health Officer has the following to say:

"Again we appeal to the physicians of the state to preach as well as to perform vaccination. While we are confident that none of you would allow a case of smallpox to occur in any of your regular patient families, how about the families you see casually. The situation throughout the State is apparently quieting down but we must see that a repetition cannot occur, and vaccination and revaccination is the only course that will prevent it.

Reports for the week ending March 20th, show a smaller number of cases of smallpox than for any of the preceding five weeks and we trust that each succeeding week will show a smaller number until there is an end of smallpox in the state. On account of the great movement of people not only between various parts of the state but from other states, constant vigilance must be maintained in order to avoid cases.

Each of us must keep the need for vaccination in mind, in spite of the fact that in the state we have vaccinated close to a quarter of a million people since the first of last January. This will help us for many years, but a large number of the other million people in the state need vaccination.

Massachusetts with a population of nearly four million did not have a single case of smallpox reported during the ten weeks from January 2 to March 13, and the only reason is because all are vaccinated as a routine early in life, vaccination being a prerequisite for attendance at school and, as this has been the custom for many years, the great mass of the population is immune and the good name of the state is protected.

If every one of us will do his part we can give our state just as good a record as is possessed by any state."

The following County Society Officers for 1926 have been reported to the Secretary:

**ALACHUA COUNTY MEDICAL SOCIETY—**

Dr. J. M. Dell, Gainesville.....*President*  
Dr. W. C. Thomas, Gainesville.....*First Vice-Pres.*  
Dr. C. L. Pridgeon, Waldo.....*Second Vice-Pres.*  
Dr. W. Lassiter, Gainesville.....*Secretary-Treas.*

**BROWARD COUNTY MEDICAL SOCIETY—**

Dr. Leslie Maxwell, Ft. Lauderdale.....*President*  
Dr. H. A. Walker, Hollywood.....*Vice-Pres.*  
Dr. R. Hippensteel, Ft. Lauderdale...*Secretary-Treas.*

**DADE COUNTY MEDICAL SOCIETY—**

Dr. R. O. Lyell, Miami.....*President*  
Dr. R. C. Woodward, Miami.....*Vice-Pres.*  
Dr. G. Raap, Miami.....*Secretary-Treas.*

**DESOTO COUNTY MEDICAL SOCIETY—**

Dr. D. L. McSwain, Arcadia.....*President*  
Dr. H. P. Bevis, Arcadia.....*Vice-Pres.*  
Dr. C. H. Kirkpatrick, Arcadia.....*Secretary*  
Dr. J. S. Coker, Limestone.....*Treasurer*

**DUVAL COUNTY MEDICAL SOCIETY—**

Dr. Herrman H. Harris, Jacksonville.....*President*  
Dr. E. T. Sellers, Jacksonville.....*Vice-Pres.*  
Dr. Louie Limbaugh, Jacksonville.....*Secretary*  
Dr. W. M. Shaw, Jacksonville.....*Treasurer*

**HILLSBORO COUNTY MEDICAL SOCIETY—**

Dr. E. W. Bitzer, Tampa.....*President*  
Dr. C. R. Marney, Tampa.....*Vice-Pres.*  
Dr. B. W. Lowry, Tampa.....*Secretary-Treas.*

**LEE COUNTY MEDICAL SOCIETY—**

Dr. A. P. Hunter, Ft. Myers.....*President*  
Dr. J. C. Nowling, Ft. Myers.....*Vice-Pres.*  
Dr. H. Quillian Jones, Ft. Myers....*Secretary-Treas.*

**MARION COUNTY MEDICAL SOCIETY—**

Dr. H. C. Dozier, Ocala.....*President*  
Dr. A. H. Freeman, Ocala.....*Vice-Pres.*  
Dr. J. L. Chalker, Ocala.....*Secretary-Treas.*

**ORANGE COUNTY MEDICAL SOCIETY—**

Dr. J. A. Pines, Orlando.....*President*  
Dr. T. M. Rivers, Kissimmee.....*Vice-Pres.*  
Dr. M. M. Andrews, Orlando.....*Secretary-Treas.*

**PINELLAS COUNTY MEDICAL SOCIETY—**

Dr. T. R. Griffin, St. Petersburg.....*President*  
Dr. L. A. Wylie, St. Petersburg.....*Vice-Pres.*  
Dr. H. L. Putnam, St. Petersburg.....*Vice-Pres.*  
Dr. O. O. Feaster, St. Petersburg.....*Secretary*  
Dr. Emil Lustig, St. Petersburg.....*Treasurer*

**POLK COUNTY MEDICAL SOCIETY—**

Dr. R. L. Cline, Lakeland.....*President*  
Dr. E. R. McMurray, Bartow.....*Vice-Pres.*  
Dr. Herman Watson, Lakeland.....*Secretary-Treas.*

**SUMTER COUNTY MEDICAL SOCIETY—**

Dr. H. S. Cherry, Center Hill.....*President*  
Dr. A. B. Albritton, Wildwood.....*Vice-Pres.*  
Dr. W. E. Mitchell, Coleman.....*Secretary-Treas.*

**TAYLOR COUNTY MEDICAL SOCIETY—**

Dr. G. H. Warren, Springdale.....*President*  
Dr. W. W. Tyson, Perry.....*Vice-Pres.*  
Dr. R. J. Greene, Perry.....*Secretary-Treas.*

**VOLUSIA COUNTY MEDICAL SOCIETY—**

Dr. C. A. Clemmer, Daytona Beach.....*President*  
Dr. L. W. Glatzau, De Land.....*Vice-Pres.*  
Dr. R. L. Miller, Daytona Beach....*Secretary-Treas.*

### IMPORTANT !

Change of local address should be sent promptly to the Editor, Box 135. If your local address is not shown correctly on our mailing list, please notify us at once, using the following blank to show change:

Full Name .....  
Street No. ....  
City ..... State.....

The Hillsborough County Medical Society uses modern methods. A check has just been received by the Secretary-Treasurer at Jacksonville for balance of dues of certain members of the Hillsborough County Medical Society by aeroplane mail service. If all outstanding dues for members in arrears were dispatched with

such haste, those responsible for the finances of the Association would have easier sailing.

Mrs. Lucille Jones, historian for St. Luke's Hospital of Jacksonville, will act as official stenographer during the annual meeting at Gainesville. Mrs. Jones has proven very valuable in this capacity at previous meetings.

## ABSTRACT DEPARTMENT

*Demonstration of the Bronchial Tree by Intratracheal Injections of Lipiodol, Henry W. Grady, M.D. The American Journal of Roentgenology and Radium Therapy, Volume XV, Number 1, Page 65.*

"The use of lipiodol, a vegetable oil containing 40 per cent by weight of iodine, in the diagnosis and localization of spinal cord tumors was reported by Sicard and Forestier in 1921. The non-irritating properties of the oil stimulated further investigation which soon resulted in utilizing lipiodol for the purpose of demonstrating the bronchial tree."

"Armande-Delille and others have used the method extensively in children, injecting the oil through the cricothyroid membrane. They found the method of great value in proving or disproving the existence of bronchiectasis in children who presented suggestive signs of tuberculosis. They discuss the value of the method in the diagnosis of bronchiectasis, interlobar empyema opening into a bronchus, pulmonary abscess and open hydatid cyst. They advise against the injection in cases of frank tuberculosis because of the possible harmful effects of iodine."

"Lipiodol has been used in a small number of cases for the purpose of demonstrating bronchiectasis and lung abscess. The inter-cricothyroid route was used in all cases. The injection is made as follows: A small curved trocar and cannula, 1.5 mm. in diameter, and having the shape of a tracheotomy tube, is used. A glass syringe with a rubber and metal connection for attachment to the cannula is provided. Under local anesthesia the trocar is introduced into the trachea through the cricothyroid membrane. A small amount (about 5 c.c.) of 1 per cent novocaine is now injected into the trachea. As soon as the cough subsides the lipiodol, which has been warmed to body temperature, is injected. The injection is made very slowly. The amount varies from 15 to 20 c.c. The position of the patient varies with the part to be injected. The patient is placed in such a position that the oil will flow

into the involved area. Elevating the shoulders slightly and turning the patient to one side causes the oil to flow into the dependent portion of the lung. Changing the degree of inclination during the injection aids in filling the bronchi. Roentgenograms are made immediately after the injection."

"The greater part of the lipiodol is eliminated by coughing within a few hours after the injection. The remainder gradually disappears, usually in one or two weeks. In one case a small amount remained in the lung four months after injection. No immediate or late ill effects of any importance have been observed."

"The number of cases in which this method has been employed is not sufficient to warrant a detailed discussion of its value. The possibility of harmful effects, though slight, cannot be dismissed from consideration. In all cases studied the diagnosis was established prior to the injection of lipiodol. However, a few points are worthy of consideration. The location and extent of the affected areas in bronchiectasis and chronic lung abscesses can be more accurately determined after the injection of lipiodol. This is a matter of some importance to the thoracic surgeon. Lesions located behind the heart shadow, or covered by densely thickened pleura, cannot be demonstrated in an ordinary roentgenogram. Because of the high content of iodine, lipiodol is very opaque to the roentgen ray, and casts a dense shadow which can be seen even when covered by the heart shadow or densely thickened pleura."

This vegetable oil which was first used in France, undoubtedly has some advantages, but it is also very expensive, almost to the point of being prohibitive in free clinics. The dry bismuth subcarbonate powder has been used successfully in this country for several years, notably by Dr. W. F. Mangees of Philadelphia. This is introduced directly into the main bronchi through the bronchoscope.

W. McL. S.



*[[ In which the Squibb Professional Service Representative  
leaves a timely reminder on Hay Fever Prophylaxis ]]*



"LISTEN Dr. Ryan! That's the first robin's song I've heard this season—and I notice your cherry trees are starting to bud."

"Yes, I believe Spring has arrived at last—it will soon be time to think about screen doors."

"Yes, doctor—and Hay Fever!"

"That's right, I must get in touch with my Hay Fever patients immediately, so they will not have a recurrence of their annual affliction."

"Now is the time to immunize them, Doctor Ryan, and I would like to remind you of Pollen Allergen Solutions Squibb which are used for the prophylaxis and treatment of Hay Fever and other pathologic conditions due to sensitiveness to pollens. Treatment should commence, as you know, five to six weeks before the ex-

pected onset of the usual seasonal occurrence in order to desensitize the patient by the time that the offending pollens make their appearance."

"As a guide for treatment, doctor, I would suggest Squibb Diagnostic Pollen Allergen Solutions. They offer the means of determining the offending pollens."

"Of what does the Squibb prophylactic treatment consist?"

"It consists of the injection of graduated doses of the glycerol solutions of the pollen proteins. Pollen Allergen Solutions Squibb are marketed in Treatment Sets, or in 5 cc. Vials."

"If, later on, you require special information on the use of these biological specialties, Dr. Ryan, just write to our Professional Service Department at 80 Beekman St., New York."

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Neo-Silvol is supplied in 1-ounce and 4-ounce bottles and in 6-grain capsules, 50 to the bottle. The contents of one capsule dissolved in a fluid drachm of water makes a 10-per-cent solution. An ointment of Neo-Silvol, 5%, in small collapsible tubes with elongated nozzle, and Vaginal Suppositories of Neo-Silvol, 5%, with a glycono-gelatin base in soft tin capsules in boxes of twelve, may also be had.

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NEO-SILVOL HAS BEEN ACCEPTED FOR INCLUSION IN THE N. N. R. BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE A. M. A.



# THE JOURNAL

— OF THE —

## Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

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No. 11

Jacksonville, Florida, May, 1926

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may be made up and ready to feed in five minutes. It flows readily through the feeding nipple.

### *Bibliography:*

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XII

Jacksonville, Florida, May, 1926

Number 11

## PRESIDENT'S ADDRESS\*

J. S. McEWAN, M.D.

Gainesville.

*Gentlemen of the Florida Medical Association:*

One of the outstanding and compelling facts obtruding upon our notice in the swiftly moving and constantly changing complexities of our every-day life is that success, in the ordinary acceptance of the term, is the natural and logical achievement of the able, skillful organizer; that, when his activities culminate in the existence of a full-fledged, functioning organization, the arduous path has been traversed, and the goal, whether professional or social, financial or industrial or economic, or all of them together, is reached.

In this paper I wish to take up the organization of the Medical Association as it stands today, with special reference to the various departments. The first thing we had to do in our reorganizing scheme was to increase the membership and arouse the enthusiasm of the members. This we have tried to do, and with the result of making our total membership nearly one thousand, from six hundred and twenty-four. This work has been mostly accomplished by our efficient secretary, Doctor Shaler Richardson, and our part time manager, Doctor Thompson, and we have proved conclusively that a whole time secretary, devoting his entire time to association work, will be a paying investment. Now that we have the members, let us adopt our new constitution, and we will have started our association, as far as organization is concerned, on a firm footing. Our relations with the State Board of Medical Examiners should be a close and cordial one and we should endeavor to keep the Board out of politics, if that is possible. What has happened during the last few years has been due to our own indifference, possibly, and not the fault of our governors. The present Board of Examiners, with their efficient Secretary, Dr. Rowlett, have done wonderful work. And due to their steadfast policy they have kept us from reciprocity with all

its attending evils. We are a peculiarly situated state and when this matter is explained to the medical fraternity of other states, most of them agree that our policy is right.

The Florida State Medical Journal is a credit to our Association, and with continued business methods employed in its publication, and with more help from the associate editors and collaborators, it can be made the best Medical Journal in the South.

We have a wonderful State Board of Health in Florida, but to be extremely successful it must have the support and have the closest co-operation between the members of our association and its component County Societies.

A review of the information obtained through recent health surveys justifies the conclusion that much progress has been made in administrative health practice and that there is a steady and growing tendency towards the standardization of public health methods. Plans for the organization of an ideal health service have been suggested for average communities of 50,000 and 100,000 population, respectively, as a result of these surveys; they represent the minimum requirements considered necessary for every community and they include the services rendered by private as well as public agencies. But the country contains many communities of 5,000 population or less, whose needs are just as important as those of 1,000,000, but who are practically without even the semblance of a health department, with few, if any, of the facilities for the promotion of the health of the community that are available to the humblest citizen—or alien—of the larger population centers.

Throughout the United States there are now some 250 county health organizations.

In the very small communities most of the work devolved upon the general practitioners, who are under any circumstances poorly paid and who have but little time to devote to public health work, but who have met the situation with the utmost devotion and comparative success.

Selecting a small community, of say 5,000 persons, the ideal health department might consist of one full-time health officer, working in co-operation with an advisory council of the County

\*Delivered before the Fifty-third Annual Meeting of the Florida Medical Association, held at Gainesville, May 4, 5, 1926.

Medical Society to formulate what general classes of work should be taken up; these would of course depend upon the type of the community concerned. An agricultural community would not particularly need a street-cleaning department. On the other hand it would most urgently need a dairy and milk inspection department, and one for the establishment and inspection of drains and the removal of surface water which is likely to be contaminated by refuse. In a city the removal of garbage becomes the duty of the health department, but in the country the garbage has to be disposed of in some other way; so that each community must solve the problem of its own individual needs. The aim should be to prevent preventable diseases; to lower the rate of infant mortality; to take effective measures in the matter of communicable diseases; to establish hospitals for the care of the sick and a public nurse, who comes in contact with the home environment and is of inestimable value in the matter of the education of the community in an intimate way. In promoting health education and in the appeal for the highest hygienic standard of living the public health nurse stands in the first rank.

It may be said that with the development of modern health programs having definite objectives, there has come a corresponding demand, more and more insistent, for the public health nurse, properly trained as such, and that the field is by no means overcrowded for an interesting and useful public service profession. Beginning with the commercial end of the question in rural health organizations (county units) the salaries of the public health nurses range from \$100.00 to \$185.00 per month, with a general average of \$140.00 per month. In industrial plants the average is from \$100.00 to \$150.00 per month, the same of city and school health nurses. Moreover the demand far exceeds the supply. Where in 1909 there were but 1,413 public health nurses in the whole United States, there were in 1922 some 12,000. In the Public Health Nurse for January, 1926, it is reported that out of a total of 3,045 counties in the United States, 1,799 counties, or 59 per cent, were without a local public health nursing service of any kind; 867 counties, or 28.5 per cent, had one or more local public health nursing services that were available to the entire county; and 379 counties had local nursing services available for only a part of the county. For the country at large the proportion is only about twelve public health nurses per 100,-

000 of population. This is all most significant. With so much yet to do and with a popular demand to have it done, the future of the public health nurse is very well worth the consideration of any woman in good health and with ambition for a career in public service, which carries its own reward as well as the more material rewards of commercial service.

In our own State, whether due to the almost perfect climate of the State, or to the boom in speculation in real estate, or from any other reason, the State has been invaded by hosts of strangers from all states and countries, bringing with them their own impediments of customs, clothes, ideas of housing, sanitation and every other conceivable condition; therefore, it behooves the body of the people to anticipate the possible consequences of these conditions. Not all states compel vaccination for children before allowing them to enter the schools. Not all people are sufficiently intelligent or sufficiently well informed to realize the benefit of vaccination in the prevention of some of the contagious diseases; therefore, it becomes the duty of the average citizen to see to it that legislation is passed to compel this preventive measure in the interest of the rest of the community.

The people coming to Florida are from different places, with different standards, with different conceptions of comfort and of hygiene, and it is the business of the community to see that they adopt the standards set by our own acquired knowledge of the needs and requirements set by our experience of them.

There is no doubt whatever that a material increase in the population of any community from whatever source produces a marked tendency to a more than corresponding increase in sickness and death in that community and proportionate measures should be anticipated to prevent it. In spite of the fact that the measures for the prevention of smallpox are well known and very effective, this disease continues to be widespread and destructive over the whole country. Reports for the calendar year of 1924 showed an increase in the number of cases of 75 per cent from 35 states, and of 628 per cent in the number of deaths from that disease as compared with the report of 1923. We have the highest rate of smallpox cases of any country of the civilized world, notwithstanding our boasted and acknowledged supremacy in sanitary laws and general hygienic eminence. It may be that the disease is



better reported here than elsewhere, but the published fact remains. When it is considered that vaccination will eliminate the danger from this particular plague, it is unfortunate that uniform laws should not be passed compelling vaccination for the safety of the community. Also, laws compelling all school children to take the Schick test for diphtheria and the Dick test for scarlet fever.

With regard to other communicable diseases, in the case of diphtheria the use of preventive measures has been, to say the least, striking. From a rate of 43.3 per 100,000 in 1900, it has been reduced to 12.1 per 100,000 in 1923; and there is no doubt but that this figure will be reduced when later reports are available. There is no reason in the world why diphtheria should not be still further greatly reduced, or even eliminated and exterminated altogether, if parents could be induced to protect their children by the use of "toxin-antitoxin" process of immunization.

One of the wonders of the present century is the reduction in the mortality of typhoid fever. At the beginning of the present century the control of typhoid fever seemed almost as hopeless as the control of influenza or measles does now. The application of measures for the purification of water and milk supplies, the exercise of vigilance in the protection of other foodstuffs, with prompt recognition of cases and supervision of carriers, have given a most striking object lesson in the result of intelligent effort applied to the protection of the public health. The typhoid death rate has dropped from 35.9 per 100,000 of population in 1900 to less than 7 per 100,000 in 1924.

Malaria is stated to be inadequately reported. There are many sections of the country that are relatively free from this disease, but in many, particularly in the Southern States, with a large colored population, it is still a serious public health problem. In Florida only a very few counties have malaria.

These may seem small and trivial measures when looked at superficially, but when examined critically, it will be seen that the younger and more energetic generation is being educated to a point where the matter of public health will be of daily importance and their community a matter of personal price. The so-called "tooth-brush

brigade" of the public school nurse has done more for the oral hygiene of the country than the whole dental profession put together.

I would recommend that provision be made for establishing full-time county health departments which will operate under medical officers whose first and only duty will be to protect, preserve and promote the public health. The county is the logical unit for this service. It preserves the home rule idea and makes for economy and permanency, and I would suggest to each county society that they take this matter up with their county commissioners and try and establish a county health unit in each county. I would, also, suggest that they back up the State Board of Health in getting increased appropriation at the next session of the Legislature, in order that they may have funds sufficient to help out those counties which are unable to pay the expenses of a full-time organization.

This county unit should have the co-operation of each individual physician residing in that county. They should see that every case of contagious disease is reported, that the correct cause of death is given and that all births are recorded. Polk County has taken the lead in the State of Florida and has established a county unit. This was established through the County Medical Society. Pinellas County is reported to have one started.

#### RECOMMENDATIONS

1. That the Association carefully consider the new constitution and by-laws to see if it is necessary to change.
2. That there be closer relations established between the councilors, editors of the Journal, State Board of Health and Medical Examining Board.
3. That our part-time business manager, Dr. Thompson, be retained.
4. That we establish county health units in all the counties of the State.
5. That we pass a resolution to obtain from the next Legislature a modification of our State Dry Law, to conform with the Volstead Act and allow the physicians of Florida to prescribe alcohol, whiskey and wine when necessary for patients.
6. That the Association should be incorporated.

# PROCEEDINGS

*of the*

## FIFTY-THIRD ANNUAL MEETING

*of the*

# FLORIDA MEDICAL ASSOCIATION

HELD AT GAINESVILLE, FLORIDA

May 4th and 5th, 1926

The Fifty-third Annual Meeting of the Florida Medical Association was called to order at 9 a.m., in the auditorium of the Elks' Club, Gainesville, Florida, by Dr. J. Maxey Dell, Gainesville, Chairman of the Committee on Arrangements. The opening prayer was made by Rev. John R. Cunningham. An Address of Welcome was given by Dr. A. A. Murphree, President of the University of Florida, followed by a Response by Dr. J. D. Love, Jacksonville. Dr. Dell made the announcements of the entertainment features of the meeting. Dr. John S. McEwan of Orlando, President of the Association, then delivered his address.\*

The meeting then adjourned. Immediately following, Dr. Frederick J. Waas, of Jacksonville, Chairman of the Scientific Program Committee, opened the Scientific Session.

### SCIENTIFIC SESSION

At the first meeting of the Scientific Assembly, the following papers were read and discussed:

"Cholecystography, Its Interpretation, with Lantern Slide Demonstration", L. W. Cunningham, in collaboration with John E. Boyd, and W. McL. Shaw, Jacksonville.

"Some Problems in Neurological Surgery", Charles Edward Downman, Atlanta, Georgia, (by invitation).

"An Analysis of Fifty Cases Showing a Basal Metabolism Rate Under Fifteen Per Cent Below Average Normal", E. W. Bitzer, Tampa.

The general meeting of the Florida Medical Association was held May 4th, 1926, in the auditorium of the Elks' Club, Gainesville, Florida, at 12:15 p.m.

Meeting called to order by Dr. John S. McEwan, President.

The following report was made by the Secretary-Treasurer and Editor, Dr. Shaler Richardson:

*To the President and Members of the Florida Medical Association, in Session at Gainesville, Florida.*

Gentlemen:

In rendering my annual report as Secretary-Treasurer, I feel that I must first acquaint you with the existing financial status of the Association at the time that I took up my duties.

At our last annual meeting at St. Petersburg the financial condition of the Association was shown to be a very prosperous one. The Secretary-Treasurer's report made it clear that the liabilities of the Association were nil, whereas the assets amounted to several hundred dollars. After acquainting myself with the office I found that the Association was indebted to the Record Company of St. Augustine to the extent of \$3,170.47. This amount was covered by note signed by your former Secretary-Treasurer and held by the above company. In view of this indebtedness, which after investigation I determined was unknown to any of the officers of the Association, I requested your President to appoint a committee to investigate the matter. He appointed an auditing committee consisting of Doctor R. H. McGinnis, Doctor H. Marshall Taylor and Doctor Ralph N. Greene. This committee worked in conjunction with your Executive Committee and rendered the following report which appeared in

\*The President's Address will be found on page 285.

the January, 1926, issue (vol. 12, No. 1, p. 201) of the Journal of the Florida Medical Association:

Jacksonville, Fla., Dec. 18, 1925.

Doctor J. S. McEwan,  
President, Florida State Medical Association,  
Orlando, Fla.

DEAR DOCTOR MCEWAN:

A special committee appointed by you in July to investigate the books of the Florida Medical Association as submitted to the present Secretary-Editor, Doctor Shaler Richardson, by the former Secretary-Editor, Doctor Graham Henson, presented to your Executive Committee the following report:

October 9th, 1925.

Doctor John S. McEwan,  
President Florida Medical Association,  
Orlando, Florida.

DEAR DOCTOR MCEWAN:

The undersigned committee appointed by yourself to investigate the books of the Florida Medical Association as submitted to the committee by the former Secretary-Treasurer-Editor, Doctor Graham E. Henson, and audited by public accountants, Messrs. Mucklow and Ford, show no discrepancy of entry.

The former Secretary-Treasurer-Editor, Doctor Graham E. Henson, has obligated the Florida Medical Association to the amount of approximately three thousand dollars (\$3,000.00) with the Florida Record Company of St. Augustine, the Record Company being the publishers of the Journal of the Florida Medical Association. The obligation is in the form of a note signed, Florida Medical Association, by Graham E. Henson, Secretary-Treasurer-Editor, and the note referred to was signed during the month of November, 1924.

It appears from the Florida Record Company's statement that Doctor Henson obligated the Florida Medical Association by a similarly signed note as above mentioned, he having given the Florida Record Company a note in the amount of five hundred dollars (\$500.00) in 1916. From time to time, after 1916, the note signed by Doctor Henson, as Secretary-Treasurer-Editor for the Florida Medical Association, has been increased in amount. For a more detailed statement of the Florida Record Company's account you are referred to Doctor Shaler Richardson, the present Secretary-Editor.

So far as your committee is advised, no officer

of the Florida Medical Association, except the former Secretary-Treasurer-Editor, Doctor Graham E. Henson, since 1916, has had any knowledge of the obligations assumed by Doctor Henson.

The former Secretary-Treasurer-Editor reported to the Florida Medical Association at its annual meeting in May, 1924, at Orlando, Florida, and at St. Petersburg, Florida, May, 1925, as appears in the proceedings of the said meetings, that the Association had no outstanding obligations. At the meeting in St. Petersburg in May, 1925, the former Secretary-Treasurer-Editor was congratulated, by a rising vote of the Association, on his commendable report, which, according to the information of your committee, is said to have shown a balance of one thousand dollars (\$1,000.00) in the treasury and no indebtedness.

The present Secretary-Treasurer-Editor, Doctor Shaler Richardson, received from the former Secretary-Treasurer-Editor, Doctor Graham E. Henson, the sum of \$307.17 when Doctor Richardson assumed his duties as successor to Doctor Henson. It appears that the books, as received by Doctor Richardson from Doctor Henson, indicate two payments to the Florida Record Company of St. Augustine in the sum of \$775.00. Said payments being made between the annual meeting at St. Petersburg, May 19th and 20th, 1925, and June, 1925. To be more explicit, it appears from the records that the payments made by Doctor Henson to the Florida Record Company at St. Augustine, were made after the St. Petersburg meeting and before turning the books over to Doctor Richardson.

When Doctor Henson filed his report at the St. Petersburg meeting in May, 1925, showing the sum of One Thousand Dollars (\$1,000.00) in the treasury and no indebtedness, he omitted to mention the note obligating the Florida Medical Association to the Florida Record Company in the sum of three thousand dollars (\$3,000.00).

It is the opinion of your committee that the above statements set forth the main facts.

We trust that the information herein contained will meet with your requirements and enable you to present the matter more clearly to your executive committee.

Respectfully,

R. H. McGinnis,  
H. M. Taylor,  
Ralph N. Greene.



A copy of this report was submitted to Doctor Henson and he was invited to be present at the meeting of the executive committee whenever it was decided to convene for the purpose of considering the report.

Doctor Henson addressed to you the following communication relating to the report of the special committee:

November second,  
Nineteen twenty-five.

Doctor J. S. McEwan,  
Orlando, Florida.

MY DEAR DOCTOR MCEWAN:

Your letter with enclosure did not reach me until today noon. As you did not state the place or date of the meeting of the Executive Committee, to be held this week, I have sent to Doctor Love a copy of this communication.

The report of the committee you sent me seems to record the transactions I had with the Record Company. There are just one or two points you would not understand without my explanation. The payments made to the Record Company between the election of Doctor Richardson and my turning the books over to him was due to the fact that at his request I carried on until the close of that month. Two hundred and seventy-five dollars was paid, as by agreement they were to be paid, for the last issue published before preparation for the succeeding issue. The other five hundred dollars had been promised them as soon as the funds became available. I would also impress your committee that the indebtedness was one that was in reality incurred when we were having a hard time to keep the Journal going, that is, during 1917 and 1918. In addition to notes held by the Record Company during that period, we had at that time also an open account. For the last several years the Journal was actually paying for itself, the indebtedness being dead wood, so to speak. Doctor Warren, who took care of the work for me while I was away during the World War, is familiar with conditions as they existed during that part of the Journal's history. To summarize: For several years we had a large open account with the Record Company in addition to a note that was carried in the St. Augustine bank. As this was paid up, another note would be given them for the open account, placed by them in the bank and the matter worked out as before. About a year ago from this date, or possibly a little earlier, the Record Company underwent a reorganization and

I had a conference with Mr. Scott Loftin, which resulted in my placing the entire indebtedness in the form of a note, with the understanding that no further open account would be run and the note retired as it could be. This arrangement had been working out for several months when I turned the affairs over to Doctor Richardson. My annual reports covered only cash transactions and you will readily understand that we at all times had both bills payable and bills receivable. A list of bills receivable was turned over to Doctor Richardson, together with an estimate of unpaid state dues from delinquent members for the current year. I trust this may clarify any misunderstanding relative to the transaction that may exist. If your committee is meeting in Jacksonville and you wish any further information, please call on me. If they are meeting outside of Jacksonville, I could not at this time very well get away. However, I think I have put everything clearly before you in this letter, and do not know of anything I could add.

With kindest regards,

Very sincerely,

Graham E. Henson.

A special call meeting of your executive committee assembled in Orlando, Florida, November 29th, to consider any matters relating to the welfare of the Association. Present at this meeting were Doctors G. H. Edwards and J. D. Love of the executive committee, President J. S. McEwan and Secretary-Treasurer-Editor Shaler Richardson. The third member of the executive committee, Doctor Joseph Halton, was absent. Doctor Graham Henson was unable to accept the invitation of the committee to be present.

It was disclosed at this meeting that when the books and accounts of the Association and Journal were turned over to the present Secretary-Editor, the liabilities in bills payable amounted to approximately \$4,386.86, this being the amount due the Record Company and covered for the most part by a note given by the previous Secretary-Editor. Bills receivable, which consisted of unpaid membership dues and advertising bills, amounted approximately to \$1,002.00. There was cash on hand, \$307.17. Further liabilities consisted in unfulfilled advertising contracts resulting from three unpublished issues of the Journal. It was decided to be to the best interests of the Association that no effort be made to publish these three issues, so long in

arrear, but to either refund to advertisers their claims on the Journal or to carry the advertising for three months of the current fiscal year. Your newly elected Secretary-Editor was confronted with the discouraging task of attempting to publish monthly editions of the Journal with the very meager assets just detailed. This was rendered more discouraging through the recently increased cost of printing a somewhat enlarged Journal, which increase amounts to approximately twenty per cent. With indefatigable determination, our Secretary-Editor has been able to meet the new indebtedness and to continue the publication of the Journal, up to the November issue, without incurring new financial obligations; though to further this accomplishment he has so far not drawn the salary due him for his services.

In order to continue the publication of the Journal throughout the fiscal year, the executive committee, with the approval of the major officers of the Association, have, through issuance of a note, secured from the Florida National Bank of Jacksonville, a credit of \$2,500.00, which may be drawn upon in units of \$500.00 as the needs of the Journal demand. The note given the bank is an obligation on the part of the Association and has the personal endorsement of the major officers and the members of the executive committee. Only such part of this credit will be used as will permit the continued publication of the Journal and to defray any debts of necessity incurred.

At the instigation and expressed wish of the Secretary-Editor, Doctor Shaler Richardson, and with the approval of the president of the Association, the executive committee has deemed it to the business interests of the Association to employ a business manager for the Journal, to function for the remaining months of the fiscal year. It is thought that through his efforts additional members might be added to the roll of the Association and new advertising matter secured for the Journal. The execution of this policy will entail but little additional expense, since the salary demanded by the contemplated business manager is merely nominal, and a large portion of it is to be secured through the generous offer of our Secretary-Editor, who donates his monthly salary to this purpose. It is believed by this committee that a competent manager will prove an asset rather than a liability to the Association; and that he will demonstrate this before the expiration of the current fiscal year.

You will realize from this report the precarious financial footing of the Association and that hope for relief is based largely on increased membership. The indebtedness to the Record Printing Company must be allowed to stand till provisions are made for its discharge.

Respectfully submitted,

Jas. D. Love,  
*Chairman, Executive Com.*  
G. H. Edwards,  
Joseph Halton.

The above report of the executive committee and special auditing committee fully informed the members of the Association of the actual financial status of the Association. In undertaking the revival of the Journal, which for several months previous to the St. Petersburg meeting had not been published, I did so after numerous deliberations with your President and Executive Committee, who were very reluctant to see the Association publication discontinued. They personally agreed to finance our work. Owing to the failure of the March, April and May issues of the Journal to appear, many of our advertisers were ready to cancel their contracts, and it was only through leniency and the effort of the Co-operative Advertising Bureau, a subsidiary of the American Medical Association, that we were able to continue a part of them. Obviously, it was necessary to forfeit the revenue that might have accrued from the advertising in the publication during its dormant months. After several months' handling of the Association and Journal affairs it was quite evident to me that our greatest need was a business manager, and for this reason I advised the officers and executive committee of the Association the necessity of such an officer. They heartily approved the plan and Doctor Stewart G. Thompson, Doctor of Public Health and Director of Vital Statistics of the Florida State Board of Health, was appointed beginning January first. Since that time he has rendered the Association an invaluable service. Due to his untiring efforts, the records of the Association at the present time are complete in every detail. He has placed the Association and the Journal on an excellent business basis.

#### *Membership*

During the past year we have made a strenuous effort to revise our membership records, and Doctor Thompson's report shows that at the present time there are 980 members in the Florida Medical Association. Each name has been

verified by the Secretary of the respective County Medical Societies. Apparently, this exceeds by nearly 300 the former maximum membership of the Association, and this, to my mind, is a creditable showing in view of the fact that the dues were doubled during the present year. We have not been able to locate authentic records of the total memberships of previous years, but the comparison of the number of paid members and total

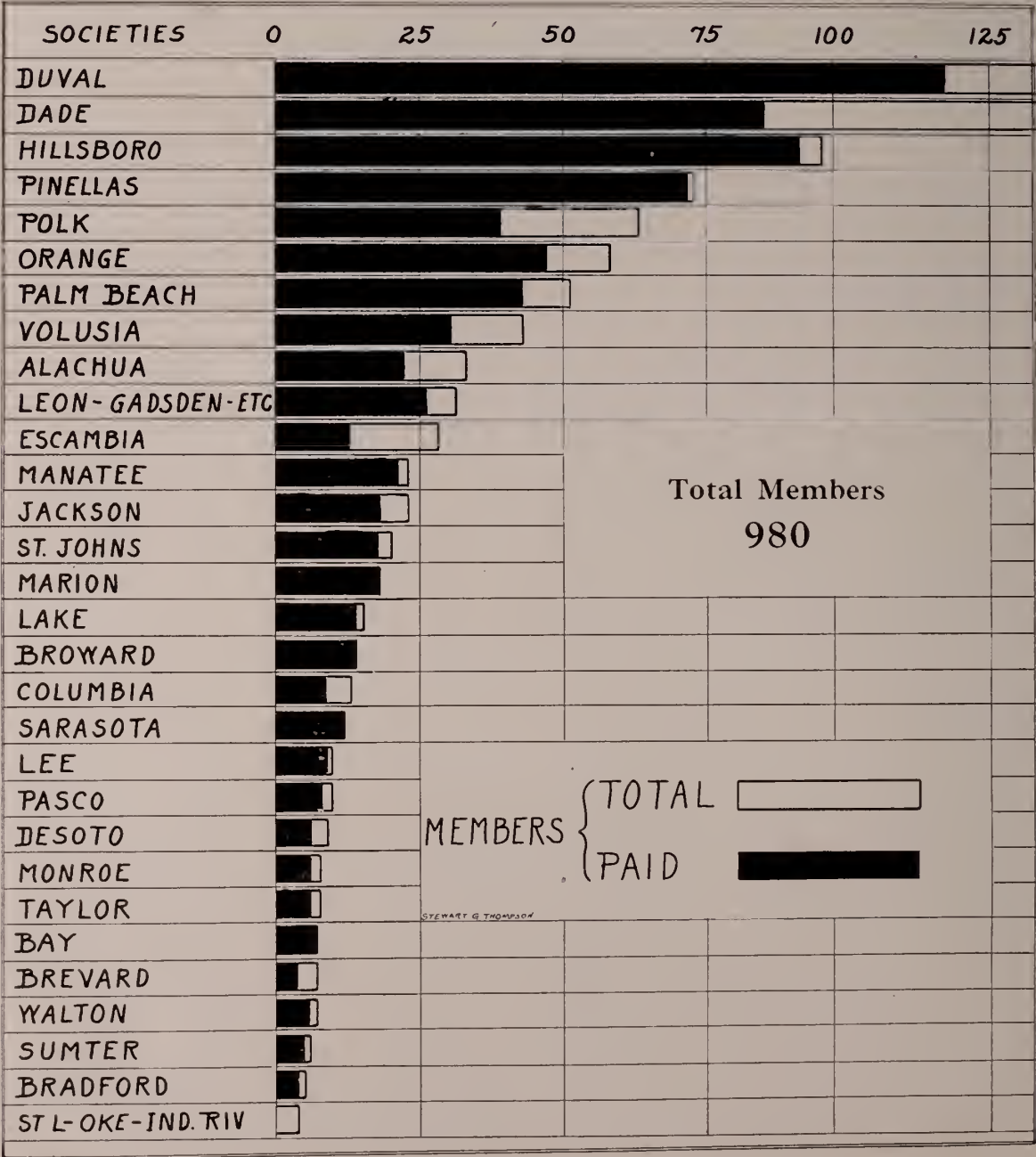
dues collected for the last three years, as reported at our annual meeting, is as follows:

Year	Members	Dues Collected
1926	794	\$8,434.00*
1925	645	3,225.00
1924	536	2,281.00

\*To May 1st.

Attached hereto is a chart showing the number

FLORIDA  
MEDICAL ASSOCIATION





of members of each County as well as the number of paid members.

### County Societies

A total of 30 counties reported during the year. Duval County shows the largest membership with a total of 135, with Dade County a close second, reporting 131 members. Hillsboro County is third, with a membership of 98.

The June, 1924, Journal shows a total of twenty-one County Societies paying dues; June, 1925, Journal a total of twenty as compared with the total of thirty for the present year. This increase in the number of County Societies reporting is an indication of the interest and general activity which our officers and business manager have stimulated. After all, the strength of the Association is measured largely by the activity and thrift of each individual society.

### Systematizing of Records

A complete revision of the records of each County Society has been made during the year. A card index file is maintained with the name of each member, address, college from which graduated, date of graduation, date of license in Florida and kind of practitioner. A systematic filing system of all correspondence pertaining to the Association and Journal has been maintained. A prospect file has been inaugurated, giving a record of the names submitted by the officers of the various County Societies with a view to aiding and securing members. No prospect, however, is interviewed or solicited until some officer of the County Society or Councillor of the District has requested help.

### Finances

A committee of three members were appointed to audit the books of the Association, and below is a copy of their report:

April 29, 1925.

Florida Medical Association.  
Gentlemen:

Your Auditing Committee has examined the books of the Sect'y-Treasurer and beg leave to report that the items that will be published in the Journal are correct and in order. We congratulate the Sect'y-Treasurer on the careful itemizing and tabulating of his accounts.

Signed,  
John Elliott Boyd, Chairman.  
R. H. McGinnis.  
G. R. Holden.

The report of Mucklow and Ford, Certified Public Accountants, is as follows:

Dr. Shaler Richardson,  
Treasurer, Florida Medical  
Association,  
Jacksonville, Florida.

DEAR SIR:

This is to CERTIFY that we have examined the attached statements of cash receipts and disbursements for the period beginning June 8, 1925, and ended April 20, 1926. These statements have been prepared by Dr. S. G. Thompson, Business Manager for Florida Medical Association and the Florida Medical Journal, and correctly reflect the total amounts received and disbursed as shown by the books.

We also checked the total amount collected from members as shown by the statement, and the total amount of unpaid dues as shown by Exhibit I with the original records and found each correct.

All of the statements hereto attached have been prepared by Dr. Thompson with the exception of Exhibits A and B, Cash Receipts and Disbursements, which show separately the status of each fund. These statements have been prepared by us.

Duplicate receipts have been checked to the Cash Receipt record. Footings of Cash Receipts and Disbursements records have been proven. Cancelled checks have been examined and compared with the disbursement record. The bank statement has been reconciled.

Yours faithfully,

MUCKLOW & FORD.

Certified Public Accountants.

By George H. Ford, C. P. A.,

Member American Institute of Accountants.

Consolidated Cash Statement from June 8, 1925, to  
April 20, 1926.

### Receipts.

Dues Account—(Exhibit "B" of Auditor's Report of June 8, 1925, attached) .....	\$ 235.47
Journal Account—(Exhibit "C" of Auditor's Report of June 8, 1925, attached) .....	71.70
Total Cash Received from former Secretary .....	\$ 307.17

### General Fund.

Dues Collected—June 8, 1925, to April 20, 1926 (Exhibit I) .....	\$7,834.00
Note—Florida National Bank .....	1,500.00
	\$ 9,334.00

*Journal Account.*

Income from Advertising (Exhibit II) .....	\$2,476.01
Earnings from Cooperative Advertising Bureau .....	54.82
Miscellaneous Sale of Journals.....	40.52
Received for Printing Plates .....	10.72

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\$ 2,582.07

Total Cash to be accounted for.. \$12,223.24

*Disbursements.*

General Fund—For Expenses (Exhibit III) .....	\$3,133.53
Journal Account — For Expenses (Exhibit III) .....	4,695.53

Total Disbursements ..... \$ 7,829.06

Balance—Cash in Bank, April 20, 1926 ..... \$ 4,394.18

## EXHIBIT I.

*Dues Collected June 8, 1925, to April 20, 1926.*

<i>Name of Society</i>	<i>Dues Paid at \$10.00</i>	<i>Dues Paid at \$5.00</i>	<i>No. in Arrears</i>	<i>Total Members</i>	<i>1926 Dues Collected</i>	<i>1925 Dues</i>
Alachua .....	12	15	6	33	\$ 195.00	\$ 40.00
Bay .....	7	0	0	7	70.00	
Bradford .....	4	0	1	5	40.00	
Brevard .....	0	7	0	7	35.00	
Broward .....	14	0	0	14	140.00	
Columbia .....	7	0	5	12	70.00	10.00
Dade .....	72	0	59	131	720.00	5.00
DeSoto .....	4	4	1	9	60.00	40.00
Duval .....	113	0	22	135	1,130.00	210.00
Escambia .....	13	0	15	28	130.00	25.00
Hillsboro .....	82	8	8	98	860.00	40.00
Jackson .....	0	0	20	20		40.00
Lake .....	14	0	1	15	140.00	
Lee .....	9	0	1	10	90.00	
Leon-Gadsden .....	20	0	11	31	200.00	30.00
Manatee .....	21	0	2	23	210.00	35.00
Marion .....	15	0	3	18	150.00	15.00
Monroe .....	6	0	2	8	60.00	30.00
Orange .....	47	1	11	59	475.00	15.00
Palm Beach .....	40	0	10	50	400.00	10.00
Pasco .....	8	0	2	10	80.00	
Pinellas .....	72	0	1	73	720.00	
Polk .....	39	0	24	63	390.00	
St. Johns .....	18	0	2	20	180.00	24.00
St. Lucie-Okeechobee-Indian River .....	0	0	4	4		
Sarasota .....	12	0	0	12	120.00	
Sumter .....	5	0	1	6	50.00	10.00
Taylor .....	6	0	2	8	60.00	
Volusia .....	28	5	10	43	305.00	70.00
Walton .....	6	0	1	7	60.00	
Individuals .....	4	1	6	11	45.00	
Totals .....	698	41	231	970	\$7,185.00	\$649.00
Dues Collected for 1925 .....					649.00	
Total Dues Collected .....					\$7,834.00	

## EXHIBIT II.

*Income from Advertising.*

June 8, 1925, to January 1, 1926 .....	\$1,452.67
January, 1926 .....	310.82
February, 1926 .....	131.54
March, 1926 .....	230.78
April, 1926 .....	350.20

Total ..... \$2,476.01

Programs .....	57.50
Badges .....	49.01
Telegrams .....	19.89
Multigraph .....	6.38
Office Furniture (Desk, \$35.00; Cabinet, \$70.65) ....	105.65
Stationery and Printing .....	100.84
Postage .....	75.15

\$3,133.53

## EXHIBIT III.

*Expenses—General Fund.*

Salaries .....	\$1,018.75
Reporting of 1925 Convention .....	75.42
Audit Expense (Mucklow & Ford) ..	20.00
Circular Letters (Dr. Greene) .....	73.60
Interest on Note of \$1,500.00 .....	22.50
Treasurer's Bond .....	17.50
Note Paid (Florida National Bank) (\$1,500.00 less discount of \$8.66) ..	1,491.34

*Expenses—Journal Account.*

Printing (Including Postage to January 1, 1926) .....	\$3,563.07
Plates for Journal .....	44.78
Refund on Advertising .....	45.00
Salaries .....	1,018.75
Postage—January to April, incl.....	23.93

\$4,695.53

Total Expenses ..... \$7,829.06

## ASSETS AND LIABILITIES.

*Assets*

Cash in Bank .....		\$4,394.18
Furniture (Safe) .....	\$ 96.66	
Furniture Purchased in 1926 .....	105.65	202.31
Stationery on hand .....		3.00
Doctors' Personal Cards on hand....		2.58
Accounts Receivable:		
Misc. Advertising Accounts .....	486.50	
Cooperative Advertising Bureau ..	152.33	638.83
231 Unpaid Dues at \$10.00.....	2,310.00	
41 Unpaid Dues at \$ 5.00.....	205.00	2,515.00
Assets .....		\$7,755.90

*Liabilities*

## CASH STATEMENT—JOURNAL FUND.

*June 8, 1925, Through April 20, 1926.**Receipts.*

Cash, as per last audit .....	\$ 71.70
Income from advertising .....	\$2,476.01
Income from Cooperative Advertising Bureau .....	54.82
Miscellaneous Sale of Journal .....	40.52
Dr. C. J. Heinberg .....	10.72
	<u>\$2,582.07</u>
Total Cash to be accounted for ..	<u>\$2,653.77</u>

*Disbursements.*

Printing (including postage to January 1, 1926) .....	\$3,563.07
Plates for Journal .....	44.78
Refund on Advertising .....	45.00
Salaries .....	1,018.75
Postage (January to April, incl.) ..	23.93
	<u>\$4,695.53</u>
Balance overdraft .....	<u>\$2,041.76</u>
Plus Balance General Fund .....	<u>6,435.94</u>
Net Cash Balance in Bank .....	<u>\$4,394.18</u>
	Exhibit A.

## CASH STATEMENT—GENERAL FUND

*June 8, 1925, Through April 20, 1926.**Receipts.*

As per statement last audit .....	\$ 235.47
Dues Collected:	
June 8, 1925, through April 20, 1926 .....	7,834.00
Note Florida National Bank .....	1,500.00
Total Cash to be accounted for ..	<u>\$9,569.47</u>

*Disbursements.*

Salaries .....	\$1,018.75
Reporting of 1925 convention .....	75.42
Audit Expense .....	20.00
Circular Letters (Dr. Greene) .....	73.60
Interest on Note (\$1,500.00) .....	22.50
Treasurer's Bond .....	17.50
Note paid Florida Natl. Bank (\$1,500.00 less disct. \$8.66) .....	1,491.34
Programs .....	57.50
Badges .....	49.01
Telegrams .....	19.89
Multigraph .....	6.38
Office Furniture (Desk, \$35.00; Cabinet, \$70.65) .....	105.65
Stationery and printing .....	100.84
Postage .....	75.15
	<u>3,133.53</u>
Cash Balance .....	<u>\$6,435.94</u>
	Exhibit B.

*The Journal*

During the past year the Journal has been published during each current month. An abstract and news item department have been added to the publication. Through the year it is rather difficult to obtain the number of original papers necessary to maintain the publication, and it is urged that the various County Societies forward all papers read before their respective organizations to the Editor of the Journal. It is only by this means that the Journal pages will be filled with worth-while reading matter.

The business manager of the Journal lets contract for Journal work only by competitive bidding when the amount is in excess of \$10.00, when practicable.

In conclusion, I wish most heartily to commend the work of Doctor Stewart G. Thompson as business manager of the Journal, and recommend to the Association his appointment on a part-time basis as Secretary-Treasurer and Business Manager of the Florida Medical Association. He has been untiring in his efforts in the work of the Association, and is now thoroughly familiar with the details of the office, and will most assuredly be an invaluable asset in the building up of our Association work in the State.

Respectfully submitted,

(Signed) SHALER RICHARDSON.

A motion was made to accept the report, and it was duly seconded and carried. Dr. James D. Love, as Chairman of the Executive Committee, submitted the following report:

*Report of The Executive Committee of The Florida Medical Association.*

In the January issue of The Journal of the Association your executive committee endeavored to present, in a brief report, something of the financial status of the Association and the difficulties being met by the Secretary-Editor of The Journal. When your executive committee investigated the business affairs of the Association it ascertained that the liabilities of the Association in bills payable amounted to \$4,386.86, this being the amount due the Record Printing Co. and covered for the most part by notes given by the previous Secretary-Editor.

Bills payable amounted to \$1,002.00, consisting of unpaid membership dues and indebtedness from advertisers. There was cash on hand, \$307.17. The liabilities of the Association were



therefore in excess of the assets over \$3,000.00. There was but little prospect of immediate replenishing of the depleted exchequer through unpaid membership dues and, furthermore, the credit of the Association was so impaired that in order to continue the publication of The Journal the major officers of the Association felt it their duty to extend such a loan as would insure the uninterrupted publication of The Journal. This end has been accomplished largely through the commendable activities of your Secretary-Editor in the face of disheartening conditions. Your executive committee realized that The Journal was not receiving as liberal patronage from advertisers as should have been given it; and felt at the same time that the Secretary-Editor was not in a position to devote more of his time than was then being given to the soliciting of business advertisements for The Journal.

Having this in mind, your executive committee approved the suggestion of the Secretary-Editor to employ a part-time business manager for The Journal and the Association. Your committee believes that the plan thus inaugurated the first of this year, through the appointment of Dr. Stewart G. Thompson as business manager, has been completely justified by the results obtained, and would strongly recommend the continuance of Dr. Thompson's services in his present capacity as part-time business manager of The Journal and the Association. Your committee believes that the financial affairs of the Association at the present time do not justify the employment of a full-time business manager, since the expense attached to such would at least treble the amount demanded by the present incumbent. From henceforth The Journal should be more largely self-supporting than it has been in the past; and the revenue derived from increased membership, increased dues and increased revenue from advertisers will enable the Association, in a comparatively short time, to discharge all present monetary obligations. It was only through the exceeding generosity of your Secretary-Editor, who donated his salary of the past four months to the cause of employing a business manager, that your executive committee felt justified in adopting this procedure. The report of the Secretary-Treasurer indicates the gratifying progress made during the past fiscal year in the way of placing the affairs of the Association on a firm financial footing. It is sincerely hoped that all outstanding obliga-

tions will be speedily retired, and that the Association will in the future enjoy such credit as befits the largest scientific body in the State of Florida. Your executive committee, realizing that with the marked increase of membership a burden would be placed on any community undertaking to entertain the Association, has recommended that, beginning with this meeting, the major expense of entertainment should be born by those wishing to participate in such entertainment. Any other course would render it nearly prohibitive that the Association be entertained by any of the small county medical societies. A meeting of two days' duration permits of the presentation of but a comparatively small number of scientific papers, and though your executive committee feels that it is perhaps exceeding its duties and prerogatives, it still feels compelled to recommend that all available time be devoted to scientific affairs of the Association; and to this end suggests that in the future all preliminary exercises be omitted from the annual program. We strongly endorse the recommendation contained in the address of your President that the Association be incorporated and would urge that the House of Delegates authorize the Secretary and Business Manager to take immediate steps to insure the enactment of this recommendation.

Your committee is appreciative of the splendid work accomplished during the past year by your retiring President and your present Secretary-Editor. Without their unflagging zeal and devotion to the cause of the Association the deplorable state which existed at the beginning of the fiscal year would not have been relieved.

(Signed) Jas. D. Love, Chairman.

A motion was made to accept the report. It was duly seconded and carried.

Report of Committee on Legislative and Public Policy, Dr. E. B. Milam, Chairman:

MR. PRESIDENT AND CHAIRMAN: Your Legislative Committee, feeling its responsibility to the Florida Medical Association as the legislative contact committee of this body, has two recommendations to make to this assembly. As you know, the Committee is made up of six members chosen from widely scattered parts of the State, the Chairman from Jacksonville, Dr. Rowlett from Tampa, Dr. Anderson from Lake City, Dr. Moor from Tallahassee, Dr. Warren from Palatka, and Dr. Calvin from Eustis. Of the Com-

mittee, four are present today. We have met and unanimously decided to recommend to this body the following two points of policy, which we suggest this body vote upon and recommend to the Legislature convening next spring in Tallahassee. As you remember, this Committee with Dr. Rowlett as Chairman had great difficulty in heading off adverse legislation at the last Legislature. We felt the undercurrent of opinion that is present there; it is not outstanding and it is hard to place your finger upon, but there is a definite, constant opposition to what organized medicine in Florida deems as best for the State as a whole. There were apparently lobbyists at the last Legislature who were working for these different sects generally, among the members of the House and Senate.

The things these two questions bring up today are of vast importance to the Association, and to organized medicine in this State. They are:

First, we recommend the placing of the office of the Secretary of the Board of Medical Examiners in the hands of a layman secretary, either part or full-time, instead of in the hands of one of our Board. I will discuss this in just a moment. The reasons for making this recommendation are manifest.

Second, we recommend the annual registration of physicians and all practitioners of the healing arts in the State of Florida. Although one member of the Board, Dr. Rowlett, I know for at least the last two years has been in favor of both these points, there has been some opposition in the Association and last year's Legislative Committee decided not to recommend it, but this year it is the unanimous opinion of the four who are present that this should be acted upon by this body today.

Now, taking up the first point, that of placing the office of the Secretary of the Board in the hands of a layman: It is easy to see that the Secretary holds a position of which I think none of us are envious. He is the constant target for just such things as have occurred within the last twelve months, with which I think all of us are familiar. There is too much detailed work for any medical man of this Association to be expected to do. There is too much chance for questions to arise for whose answer he should not be held responsible. It is absolutely unfair to take his time from the practice of medicine to be devoted to work for this organization. The fact that he is a medical secretary, mitigates against

our being accepted in a favorable light by the rural districts of Florida through their Representative at Tallahassee. It offers little of the advantages that we would have with a lay secretary in preference to a doctor. Some rule for taking examinations could then go from the Board of Medical Examiners to the Legislature through the hands of a lay secretary. Then what examinations were given would be given by a Board of Medical Examiners appointed by the Governor just as those given school teachers are given by another Board responsible to the Executive Department.

What we are seeking to do is, if possible, to bring about favorable and proper legislation through the hands of the laity, and not through the hands of ourselves, for they considered us a sort of medical trust when we appeared before the last Legislature, and thought that we were constantly trying to "put something over" on everything else in the State—but they recognized in an entirely different manner the questions constantly brought up by the laity at Tallahassee on questions of education. If through a lay Secretary our questions of public policy are brought to light and they see them from such a new angle, they will lay down proper regulations and the law will insure their being followed. The lay Secretary would report all irregularities to the proper authorities and the public as a whole would realize that it is not that we are trying to put something over on the State, but that we are for the best interests and health of the State as a whole.

The question of annual registration was proposed and recommended because we believe it will give us a closer check; it will give the Board of Medical Examiners the names in the outlying counties where the licenses are supposed to be registered, and a closer check on every practitioner coming into the State, whether he be regular or otherwise. In other words everything will be brought to light. The registration fee will probably be very small, perhaps one dollar annually, which would not work any great hardship upon any of us. Such a registration would place information before the Board and before the county authorities that would be invaluable in prosecuting corrupt practices in violation of the Medical Practice Act. We think that it would be a definite weapon in the hands of organized medicine. It would give the entire history of every man practicing the healing arts in Florida.

His license following registration would have to be in a public place in his office, and for violation of such a law we would recommend, not a fine, but a more drastic penalty in order to secure respect for such a law if passed.

We recommend that these points be added as amendments to the present medical practice act.

We present this in the form of a resolution and move its adoption."

Motion that the Chairman of the Committee on Legislative and Public Policy put these resolutions in correct form and present them at the next session.

Motion seconded and passed.

Motion by Dr. Henson that the reports of Councillors be received by the Secretary and published in the next issue of The Journal.

Motion seconded and carried.

The President, Dr. McEwan, gave the following report on the work of the Councillors for the year:

"I want you men to know that all of our Councillors have been working in every one of these twenty-one districts; that they are the men who have helped to put over this membership drive, and I want you all to give these men due credit for it. It is not the officers, because if we had not had the Councillors of all of these districts, we could not have increased our membership."

Motion to adjourn.

#### SCIENTIFIC SESSION

At 2 p.m., May 4th, the Scientific Session again convened. The following papers were read and discussed:

"Eczema, in Infancy and Childhood". William Ewing Sinclair, Orlando.

"A Plea for More Judgment in Correcting Uterine Displacements", J. S. Turberville, Century.

"The State Board of Health, Its Anatomy and Physiology", B. L. Arms, State Health Officer, Jacksonville.

"Some Observations on Chronic Gall-Bladder Diseases," J. Knox Simpson, Jacksonville.

"Surgical Treatment of Goitre", LeRoy A. Wylie, St. Petersburg.

"The Outlook in Diabetic Children", Louie Limbaugh, Jacksonville.

"Mercurochrome in the Treatment of Septicæmia of Mastoid Origin", T. H. Odeneal, W. Palm Beach.

"Fractures of the Femoral Shaft Treated by Traction", F. L. Fort, Jacksonville.

#### MEETING OF THE HOUSE OF DELEGATES

ALACHUA COUNTY MEDICAL SOCIETY  
Dr. J. M. Dell

BREVARD COUNTY MEDICAL SOCIETY  
Dr. R. F. McLeod

BROWARD COUNTY MEDICAL SOCIETY  
Dr. J. O. Stranahan

COLUMBIA COUNTY MEDICAL SOCIETY  
Dr. L. M. Anderson

DADE COUNTY MEDICAL SOCIETY  
Dr. G. Raap  
Dr. R. O. Lyell  
Dr. G. H. Benton  
Dr. M. J. Flipse

DUVAL COUNTY MEDICAL SOCIETY  
Dr. B. L. Arms  
Dr. J. E. Boyd  
Dr. W. E. Ross  
Dr. R. H. McGinnis  
Dr. H. M. Taylor  
Dr. L. W. Cunningham

ESCAMBIA COUNTY MEDICAL SOCIETY  
Dr. J. S. Turberville

HILLSBORO COUNTY MEDICAL SOCIETY  
Dr. J. S. Helms  
Dr. Wm. Rowlett  
Dr. C. R. Marney  
Dr. R. C. Hubbard

LAKE COUNTY MEDICAL SOCIETY  
Dr. M. M. Hannum

LEON-GADSDEN COUNTY MEDICAL SOCIETY  
Dr. J. Q. Folmar

MANATEE COUNTY MEDICAL SOCIETY  
Dr. T. M. McDuffie

MONROE COUNTY MEDICAL SOCIETY  
Dr. Geo. R. Plummer

ORANGE COUNTY MEDICAL SOCIETY  
Dr. G. H. Edwards  
Dr. C. D. Christ  
Dr. J. H. Ford

PALM BEACH COUNTY MEDICAL SOCIETY  
Dr. W. J. Buck  
Dr. J. H. Odeneal

PASCO COUNTY MEDICAL SOCIETY  
Dr. G. R. Creekmore

PINELLAS COUNTY MEDICAL SOCIETY  
Dr. A. C. Williams  
Dr. O. O. Feaster  
Dr. R. J. Wood  
Dr. W. M. Davis

POLK COUNTY MEDICAL SOCIETY  
Dr. R. E. Gilbert  
Dr. C. W. Love

ST. JOHNS COUNTY MEDICAL SOCIETY  
Dr. J. N. Fogarty

TAYLOR COUNTY MEDICAL SOCIETY  
Dr. J. C. Ellis

Bay, Bradford, DeSoto, Jackson, Lee, Marion, St. Lucie, Sarasota, Sumter, Volusia and Walton County Societies not represented.



Meeting called to order by Dr. John S. McEwan, President, who announced that the first order of business would be a vote on the adoption of the new Constitution and By-Laws as presented at the meeting in 1925.

Motion by Dr. Helms that substitutes be named for the official delegates and that the house be properly constituted.

Motion seconded and carried.

Dr. Christ moved the adoption of the Constitution as proposed by the Committee. Seconded by Dr. L. M. Anderson.

At the request of the President, Dr. J. S. Helms, as Chairman of the Executive Committee for 1925, gave the following resume of the Committee's motion to amend the Constitution:

"I want it understood that I am not here to advocate the adoption of the new Constitution and By-Laws of this Association. There is absolutely nothing selfish in this matter on my part. There is nothing that I want.

This proposed Constitution and By-Laws was proposed on account of the fact that there were certain difficulties that were in the way of certain things that the Societies seemed united on, that we hoped to adopt or carry out. And, for that reason, this Committee was appointed to draw up this proposed Constitution and By-Laws. If the old Constitution and By-Laws contains such things as will allow the Association to be put on the proper sort of business basis, and will allow the appointment of the proper officers to carry out the purposes and intentions of this Association—why then all well and good.

The question that came up was chiefly the employment of a whole-time Secretary. That was advocated at the last meeting at St. Petersburg, and received favorable consideration. It is not the question, and the proposed Constitution and By-Laws does not specifically state that a whole-time Secretary must be appointed, but the Secretary must be appointed or elected by the Board of Directors for whole-time if necessary or as part time. That Secretary can be a layman or he may be a medical man. It is quite elastic and would fulfill all of the purposes of the employment of a secretary, and would put the Association on an actuative basis.

It provided for a Budget Committee, to make out a budget for expenditures from year to year, and the dues of the Association would be fluctuated according to the requirements of expenditure for carrying on the business of the Association,

including THE JOURNAL. Furthermore it takes away from the general election the election of the Secretary. The Secretary has been in a position heretofore to become quite a political factor in the nomination of officers of the Association. Under the present arrangement of the new Constitution and By-Laws, if adopted, he would have that same power if he chose to exercise it.

It provided for a Nominating Committee which does away largely with bad politics in the Association, and that is a very desirable thing to do.

These are essentially the main things which are contained in the new proposed Constitution and By-Laws. If these things are in the old Constitution and By-Laws or if the Association does not want to carry out these plans and if it suits the purposes of the powers that be for or otherwise, why then it will be no use to adopt a new Constitution and By-Laws—not unless it is for the best interest of the Florida Medical Association and put it on a basis in keeping with the progress of Medicine in Florida.

After general discussion, it was moved, seconded and carried that the proposed new Constitution and By-Laws be not adopted.

Dr. R. H. McGinnis then moved that instead of fourteen Councillors, that there be one for every district. Voted and carried.

The following memorandum forwarded by the Executive Secretary, Bureau of Legal Medicine and Legislation of the American Medical Association, was read by the Secretary:

"MEMORANDUM SHOWING THE EFFECT ON THE MEDICAL PROFESSION OF THE ENACTMENT OF S. 4085, A BILL TO STRENGTHEN THE HARRISON NARCOTIC ACT OF DECEMBER 17, 1914, AS AMENDED, AND FOR OTHER PURPOSES, INTRODUCED INTO THE UNITED STATES SENATE BY SENATOR SMOOT, APRIL 24, 1926, AND NOW PENDING BEFORE THE SENATE COMMITTEE ON FINANCE.

The Enactment of the bill named in the heading would cause the following changes in the law, of direct interest to physicians:

1. Any collector of internal revenue could refuse to register any physician whom he thought addicted to the habitual use of narcotics. The physician would be entitled to no preliminary notice and no hearing.

2. Any physician convicted of any violation of the Harrison Narcotic Act, no matter how trivial

and technical, would necessarily be denied registration under the Act until after the expiration of one year following the 1st of July next following his conviction. This would be in addition to all other penalties that might be imposed under the Act.

3. No physician could dispense or distribute any narcotic drug to any patient in the course of the so-called ambulatory treatment of narcotic addiction.

4. Every physician would have to keep a record of all narcotic drugs dispensed or distributed by him, except those dispensed or distributed "in emergency cases only." Now he is not required under the Harrison Narcotic Act to keep a record of such as he dispenses or distributes to patients on whom he is in personal attendance, except in the case of dispensing physicians who dispense or distribute any of the so-called exempt narcotic preparations; *see paragraph 6 below*.

5. No physician's prescription for narcotics could be lawfully filled by any pharmacist if the circumstances were such that the pharmacist "might reasonably deduce" from them that the prescription was not issued by the physician in the course of his professional practice only. The bill does not define what constitutes "the course of professional practice only."

6. A physician distributing or dispensing any of the so-called exempt narcotic preparations would have to keep a record of his *purchases* of such preparations. Now he is required to keep a record of only sales, exchanges, and gifts."

Motion by Dr. J. S. Helms that it is the sense of this Association that this bill is a piece of pernicious legislation and the Florida Medical Association should go on record opposing it.

Motion seconded by Dr. R. H. McGinnis, with this addition: "That the Secretary write them a letter to this effect." Voted and carried.

Dr. Helms moved that the new Executive Committee, when appointed, be authorized to proceed and take the necessary steps to have the Florida Medical Association incorporated according to the laws of the State of Florida, as a corporation not for profit.

Motion seconded and carried.

Motion by Dr. Christ that the Florida State Medical Association in annual convention at Gainesville, Florida, petition the Florida State Legislature to so amend the present state dry law as to allow physicians to prescribe spirits and fer-

mented alcohols in conformity with the National Volstead law.

Motion seconded and voted, but lost.

An invitation was extended by the Palm Beach County Medical Society to the Florida Medical Association to hold the annual convention at West Palm Beach in 1927.

Dr. Helms then announced that the Hillsborough County Medical Society also requested the convention to be held in Tampa.

West Palm Beach selected for the annual convention, May, 1927.

Dr. McDuffy of Manatee moved that the Association favor a law requiring all children in the State of Florida to be vaccinated against smallpox and diphtheria before being admitted to public school.

Dr. Helms then offered a motion that this be referred to the Committee on Legislative and Public Policy for action, which was seconded and carried.

Motion to adjourn.

#### SCIENTIFIC SESSION

The third Scientific Session was called to order at 9 a.m., May 5th, and the following papers were read and discussed:

"Bronchial Asthma and Its Relation to Sinus Disease in Children", M. A. Lischkoff, Pensacola.

"Lead Poisoning in Children", Luther W. Holloway, Jacksonville.

"The Estimation of Heart Reserve", Julian E. Gammon, Jacksonville.

"Labor, Normal and Abnormal", S. R. Norris, Jacksonville.

"Early Diagnosis of Tuberculosis", W. A. Claxton, District Medical Officer, Miami, State Board of Health.

"Some Pre-operative Factors Influencing the Mortality of Prostatectomy", John E. Hall, West Palm Beach.

"Additional Scraps from Memory's Storehouse of Sanitary Doings in Florida During the Past Half Century, Joseph Y. Porter, Key West. (Read by Title Only.)

#### GENERAL MEETING OF THE ASSOCIATION

The General Session of the Florida Medical Association again convened at 12:00 o'clock noon, Wednesday, May 5th, 1926, Gainesville, Florida.

Meeting called to order by Dr. John S. McEwan, President.

A report from the Committee on Legislative and Public Policy relative to amending the medical practice act, was read by Dr. Shaler Richardson, Secretary.

*Be it resolved*, That it is the sense of the Florida Medical Association, in annual session assembled, that the Medical Practice Act be amended to provide for (1) the annual registration of physicians and all practitioners of the healing art; (2) the office of Secretary of the Board of Medical Examiners being placed in the hands of a layman rather than a physician as at present provided for.

*Be it further resolved*, That the Committee on Legislation and Public Policy be instructed to use all necessary effort to secure the enactment of legislation providing for these amendments to the present Medical Practice Act.

Ernest Milam, Chairman.

W. M. Rowlett.

L. M. Anderson.

F. Clifton Moor.

Motion to adopt report carried. Report accepted.

Dr. Anderson of Lake City read the following resolution:

WHEREAS, it appears that there is a very decided and urgent need for adequate treatment of the tuberculous in this State and,

WHEREAS, the Florida Public Health Association has requested our cooperation with them and other representative state organizations such as:

The State Department of Health, American Legion, Florida Federation of Women's Clubs, State Dental Society, State Parent-Teachers' Association, etc., in the promotion of a State Sanatorium,

THEREFORE, be it resolved that the State Medical Society endorse this action of the Florida Public Health Association and that the President appoint a committee to represent the State Medical Association in this great movement.

(Signed) L. M. Anderson.

Motion to adopt, carried.

#### *Annual Election of Officers*

Upon motion, Dr. H. Mason Smith of Tampa was unanimously elected President of the Florida Medical Association for the year 1925-1926.

Dr. J. S. Helms and Dr. J. E. Boyd appointed by the President to escort Dr. Smith to the Chair.

*Dr. H. Mason Smith:*

"To the Members of the Florida Medical Association:

"There are times in one's life when a moment surges forward so strongly and so rapidly that he cannot give expression to any consecutive thoughts, and on being elected your President, I find myself in such a state at this time.

"There is one idea, though, which I desire to get across—that I hereby dedicate myself to the welfare of the Florida Medical Association, and pledge myself to make any sacrifice, either personal or financial, in my power to carry on the work during the coming year.

"I desire to pay tribute to the retiring President. He has been the most faithful worker for the welfare of this organization that I have ever known, and it will be my endeavor to emulate his example.

"I thank you for the honor conferred."

The Past Presidents' Emblem was presented to Dr. McEwan by Dr. Anderson of Lake City:

"Dr. McEwan, in presenting you with this emblem, I feel, Sir, that you have honored our Association, and we feel honored, and it is with the greatest pleasure that I pin this button on you as the insignia of a Past President of the Florida Medical Association."

Dr. Frederick J. Waas of Jacksonville nominated by Dr. Boyd for first Vice President. Nomination seconded.

Dr. J. N. Fogarty of St. Augustine nominated for first Vice President by Dr. Milam. Nomination seconded.

Vote by ballot with Dr. Anderson, Dr. Christ and Dr. Stringer as tellers. Dr. Wass, 68; Dr. Fogarty, 55. Dr. Waas received the majority of votes and was declared first Vice President.

*Dr. Waas:*

"Gentlemen, I want to thank you for the honor conferred upon me, one that I very deeply appreciate. It is going to be my very great pleasure to cooperate with our efficient President in putting over the program that he expects to for the coming year.

"I want to assure you that it is an honor I will never forget, and I certainly do appreciate it from the bottom of my heart.

"I thank you, Gentlemen."



Dr. Herman Watson of Lakeland and Dr. G. H. Edwards of Orlando nominated second Vice President, but at their request nominations withdrawn.

Dr. J. Maxey Dell of Gainesville nominated and unanimously elected second Vice President.

Dr. A. G. Fort of Miami nominated third Vice President. Nomination seconded and carried.

Upon motion made, seconded and carried, Dr. Shaler Richardson was unanimously re-elected Secretary-Treasurer of the Association and Editor of the Journal.

Motion made, seconded and carried that the Secretary receive the report of the Committee on Necrology and publish it in The Journal.

Upon motion by Dr. Anderson, the Association extended a rising vote of thanks to the physicians of Gainesville, and particularly to Dr. Dell, Chairman of the Committee on Arrangements, for the numerous entertainments and courtesies extended the Association during the present convention.

On motion duly made, seconded and carried, the meeting adjourned, sine die.

### SCIENTIFIC SESSION

The last session of the Scientific Assembly was called to order at 2 P. M., May 5th. The following papers were read and discussed:

"The Causes of Insanity," W. H. Spiers, Orlando.

"Squint—The Cooperation of the General Profession and the Ophthalmologist in the Treatment of Same," Hewett Johnston, Orlando.

"Report of Cases. Conditions Following Ureteral Stricture," Edmund H. Teeter, Jacksonville.

"Pyelitis Complicating Pregnancy," I. M. Hay, St. Augustine.

### PROCEEDINGS OF THE SIXTH ANNUAL MEETING OF THE FLORIDA RAILWAY SURGEONS' ASSOCIATION

*Held at Gainesville, Florida, May 3, 1926.*

Meeting of the Florida Railway Surgeons' Association called to order by Dr. Joseph Halton, President, at 2:10 p. m., May 3, 1926, at the Elks Club auditorium.

Invocation by Rev. T. V. McCaul, Pastor of the First Baptist Church of Gainesville, Fla.

Address of Welcome by Dr. J. M. Dell of Gainesville, President, Alachua Co. Medical So-

ciety. Response by Dr. J. N. Fogarty, Chief Surgeon, F. E. C. Ry., St. Augustine, Fla., in the absence of Dr. R. N. Greene of Jacksonville, Fla.

President's address, Dr. Joseph Halton, Sarasota:

"The professional man's inborn desire to seek, to know, has been the dominant factor in the advancement of the medical world. The constant craving of his soul to explore the great unknown is ever present. No task too great, no burden too heavy but what he will carry on in order that he may conquer the physical ills that assail the human race. His inquiring mind will never be satisfied. It makes of him a mental prodigal. Scattering among his fellow practitioners the riches of his mind, giving freely his thoughts and his knowledge and receiving meekly all the new ideas that he may acquire.

Once again we meet to impart the experiences of our past years. Once again to renew old acquaintanceships and again to drink the water of new ideas or old ideas made new by reiteration. Fortunate are the men who periodically meet to impart their experiences and absorb those of others. How wonderful is this annual feast of knowledge! No man can lose who takes the opportunity to listen to the ideas of others, especially when these ideas have been acquired and crystallized after long years of observation, study and practice.

Here we peep into other minds. Here we glean the thoughts of others and in return let them gaze into the book of our own ideas. Here we carefully weigh the statements of one and fervently disagree with those of another. What respect we pay the author of a paper. No orator or preacher receives such intent attention as does the author of some essay read at our meetings. It is indeed a compliment to have the privilege to appear before such a body of learned men.

How well we praise the good work of one and generously overlook the mistakes of another. How this meeting broadens one's mind and makes us kinder in criticisms.

The value of these meetings is based on the fact that we do not receive the lasting impression from reading a paper at home that we get from hearing a paper read by its author. The personal contact causes our minds to receive like clay and retain like marble. Some ideas are re-born and fixed forever. Long forgotten cases are recalled, and our mental cobwebs are swept

away and replaced by a refreshing, clear, mental atmosphere. How often do we cry out for mental association in our chosen line. How few times do we chance to sit at the feet of some great teacher.

How scarce are our opportunities to witness the marvelous skill of a great surgeon. The one great thing we all must feel is the lack of mental association. This is even more obvious to the men from the smaller localities, where the medical meetings are few and clinics unknown. I gladly have accepted and discharged the occupancy of this, your presidential chair. It has been an honor to have served you, a privilege to have been your presiding officer. May these meetings grow and may every member become the author of a paper to be read at a future meeting."

Dr. E. W. Warren, Secretary, was unable to be present on account of illness.

Applications for membership of the following surgeons were read and the applicants were duly elected: Drs. W. N. Parkinson, F. E. C. Ry., St. Augustine, Fla.; W. E. Burnett, F. E. C. Ry., St. Augustine; Z. Brantley, Southern Ry., Grandin, Fla.

Election of officers for ensuing year was next in order and resulted as follows: Dr. J. N. Fogarty, Chief Surgeon, F. E. C. Ry., St. Augustine, President; Dr. G. C. Tillman, A. C. L. Ry., Gainesville, Vice President; Dr. E. W. Warren, F. E. C. and Southern Rys., Palatka, Secretary-Treasurer, all elected by acclamation.

Moved and carried that the association express its sympathy for Dr. E. W. Warren, who was ill and in hospital, and express a hope for his early recovery.

Meeting turned over to Dr. G. H. Edwards, A. C. L. Ry., Orlando, Chairman, Program Committee.

### *Scientific Program.*

"Spinal Puncture as Treatment in Cranial Fractures," by Dr. Fred Bowen, F. E. C. Ry., Jacksonville.

Discussion by Drs. J. N. Fogarty, St. Augustine; J. S. Turberville, L. & N. Ry., Century; Joseph Halton, S. A. L. Ry., Sarasota; Dr. J. S. McEwan, A. C. L., Orlando; Forest, DeLand; T. M. Rivers, A. C. L. Ry., Kissimmee, and Dr. C. D. Christ, Orlando. Closed by Dr. Bowen.

"Considering the Patient in Pneumonia," Dr.

Mary Freeman, F. E. C. Ry., Perrine. Telegram from Dr. Freeman saying impossible to come on account of illness in family. Moved and carried that association express by wire its regrets to Dr. Freeman.

"Use of Alcohol in First Treatment," Dr. J. C. Nowling, Ft. Myers, A. C. L. R. R.

Discussion by Drs. L. M. Anderson, Southern Ry., Lake City; J. W. Alsobrook, A. C. L. Ry., Plant City; G. C. Tillman, A. C. L. Ry., Gainesville; closed by Dr. Nowling.

"Interesting and Unusual Cases Gleaned from a General Practice of 34 Years," by Dr. Henry E. Palmer, S. A. L. Ry., Tallahassee.

Discussion by Drs. Joseph Halton, Sarasota; L. M. Anderson, Lake City; H. C. Dozier, A. C. L. Ry., Ocala; J. W. Alsobrook, Plant City; J. S. Turberville, Century; J. C. Davis, S. A. L. Ry., Quincy; C. D. Christ, S. A. L. Ry., Orlando; T. M. McDuffie, S. A. L. Ry., Bradenton; closed by Dr. Palmer.

"Medical Center in the South," a talk by Dr. R. B. Slocum, Supt. and Med. Director, A. C. L. Ry., Wilmington, N. C.

President Halton resumed the chair and installed the incoming officers.

West Palm Beach will be the next meeting place.

## REGISTRATION

The following registered during the Fifty-third Annual Meeting of the Florida Medical Association held at Gainesville, May 4-5:

### OFFICERS

John S. McEwan, President	Orlando
H. Mason Smith, 1st Vice President	Tampa
Carl A. Williams, 2nd Vice President	St. Petersburg
Shaler Richardson, Sec'y-Treas.	Jacksonville
Stewart G. Thompson, Business Mgr.	Jacksonville

### MEMBERS

#### *Alachua County Medical Society.*

Z. Brantley	Grandin
E. L. Biggs	Starke
J. H. Colson	Gainesville
I. A. Dailey	Micanopy
J. Maxey Dell	Gainesville
M. H. DePass	Gainesville
W. T. Elmore	Gainesville
G. M. Floyd	Hawthorne
S. P. Getzen	Newberry
J. A. Goode	Alachua
C. R. Gray	Trenton
J. H. Hodges	Gainesville
W. Lassiter	Gainesville
H. F. Preston	Melrose

C. L. Pridgeon	Waldo
S. D. Rice	Gainesville
W. F. Rosborough	Micanopy
G. W. Sherouse	Campville
D. T. Smith	Gainesville
J. L. Summerlin	Gainesville
W. C. Thomas	Gainesville
G. C. Tillman	Gainesville
J. H. Twiggs	Archer
J. D. Watkins	Micanopy
L. R. Weeks	Trenton
J. M. Willis	Williston
W. C. Young	Chiefland

*Bradford County Medical Society.*

John E. Maines	Lake Butler
John M. Mann	Lake Butler
W. E. Middleton	Starke

*Brevard County Medical Society*

A. F. Thomas	Titusville
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*Broward County Medical Society*

R. Hippensteel	Ft. Lauderdale
R. B. Lingeman	Ft. Lauderdale
L. H. Maxwell	Ft. Lauderdale
R. E. Repass	Hollywood
J. O. Stranahan	Ft. Lauderdale
H. A. Walker	Hollywood

*Columbia County Medical Society*

L. M. Anderson	Lake City
L. J. Arnold	Lake City
A. L. Blalock	Madison
Herbert Caldwell	Lake City
James H. Dyer	Lake City
P. C. Farnell	Lake City
John D. Gable	Lake City
R. B. Harkness	Lake City
C. M. Tyre	High Springs
W. E. Whitlock	High Springs

*Dade County Medical Society*

G. H. Benton	Coral Gables
Scott R. Edwards	Miami Beach
M. J. Flipse	Miami
A. G. Fort	Miami
E. D. French	Miami
F. A. Gowdy	Miami
E. J. Hall	Miami
D. W. Harris	Miami
B. F. Hodson	Miami
Thos. W. Hutson	Miami
R. O. Lyell	Miami
Bascom H. Palmer	Miami
Cayetano Panettiere	Miami Beach
Edgar Peters	Miami
G. Raap	Miami
E. Clay Shaw	Miami Beach
Tom A. Williams	Miami

*DeSoto County Medical Society.*

H. P. Bevis	Arcadia
C. H. Kirkpatrick	Arcadia

*Duval County Medical Society.*

W. Herbert Adams	Jacksonville
B. L. Arms	Jacksonville
John A. Beals	Jacksonville
F. A. Brink	Jacksonville
W. D. Brinson	Baldwin
John E. Boyd	Jacksonville
Frederick Bowen	Jacksonville
T. Z. Cason	Jacksonville
C. C. Collins	Jacksonville
S. M. Copeland	Jacksonville

L. W. Cunningham	Jacksonville
Gaston Day	Jacksonville
R. H. Dean	Jacksonville
S. E. Driskell	Jacksonville
Stanley Erwin	Jacksonville
T. S. Field	Jacksonville
L. G. Fisher	Green Cove Springs
F. L. Fort	Jacksonville
Julian Gammon	Jacksonville
B. H. Goodale	Jacksonville
Ralph Greene	Jacksonville
D. E. Harrell	Jacksonville
Herman H. Harris	Jacksonville
W. G. Harris	Jacksonville
Graham E. Henson	Jacksonville
Gerry R. Holden	Jacksonville
L. Holloway	Jacksonville
Edward Jelks	Jacksonville
C. L. Jennings	Jacksonville
W. W. Kirk	Jacksonville
Louie Limbaugh	Jacksonville
Jas. D. Love	Jacksonville
R. H. McGinnis	Jacksonville
Robt. B. McIver	Jacksonville
C. B. Mabry	Jacksonville
W. S. Manning	Jacksonville
E. B. Milam	Jacksonville
S. R. Norris	Jacksonville
G. F. Oetjen	Jacksonville
James D. Pasco	Jacksonville
H. A. Peyton	Jacksonville
J. H. Randolph	Jacksonville
F. Richards	Jacksonville
Shaler Richardson	Jacksonville
D. C. Rollins	Jacksonville
Wm. E. Ross	Jacksonville
Raymond Sanderson	Jacksonville
E. T. Sellers	Jacksonville
W. M. Shaw	Jacksonville
F. M. Sheppard	South Jacksonville
J. Knox Simpson	Jacksonville
E. C. Swift	Jacksonville
H. M. Taylor	Jacksonville
E. H. Teeter	Jacksonville
Harold D. Van Schaick	Jacksonville
F. J. Waas	Jacksonville
Clayton Washburn	Jacksonville
A. K. Wilson	Jacksonville
B. F. Woolsey	Jacksonville

*Escambia County Medical Society*

M. A. Lischkoff	Pensacola
W. C. Payne	Pensacola
J. S. Turberville	Century

*Hillsboro County Medical Society*

J. W. Alsobrook	Plant City
A. M. Bidwell	Tampa
E. W. Bitzer	Tampa
W. C. Blake	Tampa
Geo. L. Cook	Tampa
J. C. Dickinson	Tampa
A. D. Draper	Tampa
R. R. Duke	Tampa
R. A. Ely	Tampa
E. S. Gilmer	Tampa
G. E. W. Hardy	Tampa
J. S. Helms	Tampa
A. F. Higgins	Tampa
W. J. Holton	Plant City
R. C. Hubbard	Tampa
A. C. Ives	Tampa
Rollin Jefferson	Tampa
A. M. Jobson	Tampa
B. W. Lowry	Tampa
E. H. McRay	Tampa
D. Mieghen	Tampa
Robert Nelson	Tampa



L. S. Oppenheimer	Tampa
W. M. Rowlett	Tampa
N. L. Spengler	Tampa
Sheldon Stringer	Tampa
Joseph W. Taylor	Tampa
H. Williams	Tampa

*Jackson County Medical Society*

M. Q. Burns	Blountstown
R. L. Kennedy	Malone
R. L. Miller	Graceville

*Lake County Medical Society*

Clyde Brady	Leesburg
M. M. Hannum	Eustis
S. H. Toy	Umatilla

*Lee County Medical Society*

J. C. Nowling	Ft. Myers
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*Leon-Gadsden County Medical Society*

J. C. Davis	Quincy
J. Q. Folmer	Chattahoochee
W. C. McConnell	Chattahoochee
F. Clifton Moor	Tallahassee
H. E. Palmer	Tallahassee

*Manatee County Medical Society*

J. M. Davis	Bradenton
J. K. Haygood	Bradenton
S. G. Hollingsworth	Bradenton
C. W. Larrabee	Bradenton
T. M. McDuffie	Manatee
J. F. Mason	Manatee

*Marion County Medical Society*

J. L. Chalker	Ocala
J. F. Curry	Dunnellon
H. C. Dozier	Ocala
A. H. Freeman	Ocala
E. G. Lindner	Ocala
H. F. Watt	Ocala

*Monroe County Medical Society*

Jos. Y. Porter	Key West
Geo. R. Plummer	Key West

*Orange County Medical Society*

M. M. Andrews	Orlando
C. D. Christ	Orlando
J. H. Edward	Orlando
J. A. Ford	Orlando
Hewett Johnston	Orlando
W. T. Langley	Sanford
R. F. McLeod	Titusville
C. I. Marshall	Sanford
G. S. Osincup	Orlando
J. A. Pines	Orlando
T. M. Rivers	Kissimmee
Sam R. Scott	Ocoee
W. E. Sinclair	Orlando
W. H. Spiers	Orlando

*Palm Beach County Medical Society*

William Buck	W. Palm Beach
Geo. M. Dawson	W. Palm Beach
John E. Hall	W. Palm Beach
T. H. Odeneal	W. Palm Beach
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H. MASON SMITH, M.D.  
President of the Florida Medical Association.

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### OUR PRESIDENT

At the general meeting of the Association held in Gainesville, May 4th, Doctor H. Mason Smith of Tampa was elected President. The honor and responsibility of this office falls on the shoulders of one eminently qualified for the position.

Dr. Smith was born in Douglasville, Ga., May 10, 1884. He was educated in the Douglasville

High School and the University of Georgia, and is a graduate of the Medical Department of the University of Georgia, class of 1908. He did general practice in Milton, Florida, until 1914. From that time until 1917 he was a member of the Medical Staff of the Florida State Hospital. He served as Superintendent of this Institution from 1917 to 1921. He has been practicing in Tampa since 1921, specializing in Neurology. During the late war he was on duty in the Neurological Institute in New York. Last year Doctor Smith was appointed a member of the State Board of Health for a period of four years. He is a member of the Hillsboro County Association, Southern Medical Association, American Medical Association, American Psychiatric Association. Doctor Smith's work in the Association has at all times been outstanding. He has served on a number of important committees and has always displayed the greatest enthusiasm in the upbuilding of organized medicine in Florida.



THE GAINESVILLE MEETING

The attendance at the meeting of the Association held in Gainesville, May 4 and 5, exceeded that of any of our former meetings. There were 270 members of the Association registered.

The scientific program was replete with interest and the discussion of the various papers show that great interest was manifested by those attending the sessions.

The social events were well planned and carried out and Alachua County Medical Society is to be congratulated on the excellent way in which they handled the meeting.

There were a number of Commercial Exhibits, special space having been set aside for them.

West Palm Beach was selected as our next annual meeting place, and it is expected that our attendance next year will even exceed that of the Gainesville meeting. The local Committee on Arrangements is already active in its planning for the next meeting.

“When you come to consider that all through our lives we go on suffering from a cold and pneumonia, from mastoiditis and the sinus troubles, and a thousand and one things which develop out of the common cold, to say nothing of the inherent weakening of the physical structure by these repeated assaults upon ourselves, but more particularly upon our children and our women, you realize the gravity of the common cold.

“Do you realize that ten days of every man, woman, and child’s activity a year, on the average, are lost throughout this country? It amounts to more than a million years of activity annually. The loss to agriculture, industry and all business activities is some 700,000 years of working time through the incapacitation of 15,000,000 workers in this country.”

The American Drug Manufacturers’ Association voted to cooperate with The Chemical Foundation in seeking a method to check the ravages of colds.

GARVAN LEADS FIGHT ON COMMON COLD

A research to discover the cause and a cure for the common cold, which was pronounced one of the greatest scourges of humanity, was undertaken by the American Drug Manufacturers’ Association at its convention in New York City recently, when an offer to finance such a research was made by Francis P. Garvan, President of the Chemical Foundation.

Reporting good progress in the fight to establish the chemical industry in this country in competition with Germany in the fields which Germany formerly controlled, Mr. Garvan branched into the subject of the common cold, which he said was one of the greatest causes of mortality and economic loss, in spite of the fact that it is usually regarded as of slight importance. He said:

“Sitting at my desk, it seems to be as if a new industry was born in this country every minute, fathered by chemistry and mothered by research. But recently, in my pride and boasting of our achievements, the curtain lifted over something undone, a problem I have brought to you and which has, I might almost say, overwhelmed me in its importance and in the little that has been done with it. This is the subject of the common cold.

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## SCHEDULE OF MEETINGS COMPONENT SOCIETIES

County Society	MEETINGS			
	Date	Time	Place	Luncheon?
Broward . . . . .	Monthly	8:00 P.M.	Ft. Lauderdale High School	No.
Dade . . . . .	1st Friday each Month	8:30 P.M.	Miami City Club	Occasionally.
DeSoto . . . . .	Regularly		Hospital	No.
Duval . . . . .	1st Tuesday each Month	8:15 P.M.	Arnold-Edw. Auditorium	No.
Escambia . . . . .	1st Tuesday each Month	8:00 P.M.	Board of Health Building	No.
Hillsboro . . . . .	1st and 3rd Tuesdays	8:00 P.M.	City Hall	No.
Jackson . . . . .	2nd Tuesday each Month	3:00 P.M.	Marianna, Fla.	No.
Lake . . . . .	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.
Lee . . . . .	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.
Leon-Gadsden . . . . .	Quarterly	3:00 P.M.	Varies	Yes.
Marion . . . . .	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.
Orange . . . . .	3rd Wednesday	8:30 P.M.	Announced	No.
Palm Beach . . . . .	2nd Monday	8:00 P.M.	Varies	Yes.
Pasco . . . . .	2nd Tuesday	8:00 P.M.	Varies	Yes.
Pinellas . . . . .	Every 2nd Friday	8:00 P.M.	Fla. Art School	No.
Polk . . . . .	2nd Wed. in Feb., Apr., June, Aug., Oct., Dec.		Lakeland	Yes.
Sumter . . . . .	Monthly			No.
Taylor . . . . .	Last Thursday, Monthly	12:15 P.M.	Eldora Cafe	Yes.
Volusia . . . . .	2nd Tuesday	7:30 P.M.	Varies	Yes.
Walton . . . . .	3rd Thursday	8:00 P.M.	Varies	Occasionally.

## SPINAL PUNCTURE AS TREATMENT IN CRANIAL FRACTURES\*

FREDERICK BOWEN, M.D., AND HAROLD D. VAN SCHAICK, M.D.,  
Jacksonville.

In our work in cranial injuries we have had certain facts and information concerning the use of Spinal Puncture in the treatment of such injuries brought forcibly home to us. There is nothing particularly new or startling in this knowledge, but it may be worth while to review.

Spinal Puncture has been used for some time in the treatment of head injuries, but it was not until the past few years that sufficient knowledge has accumulated concerning the cerebro-spinal fluid to enable one to state definitely which case shall or shall not be so treated.

The cerebro-spinal fluid so far as we know is an active secretion of the choroid plexus mainly, added to by ependymal cells of the ventricles, the pituitary body and the metabolic products of the brain cells themselves through their perivascular channels.

There is a definite circulation from its origin in the lateral ventricles through the foramen Monroe to the third ventricle, then through the aqueduct of Sylvius to the fourth ventricle, where it escapes through the foramen of Magende and Luschka to the subarachnoid spaces beneath the tentorium and the large cisterna at the base of the brain.

From the cisterna the fluid follows two paths mainly. The large part rises over the surface of the brain through the incisura tentorii and is absorbed chiefly into the large venous sinuses by means of the pachionian bodies. The smaller portion descends along the ventral aspect of the cord and returns along the dorsal aspect. These two streams are partly separated by the ligamenta denticulata and the spinal nerves.

Thus the main path of the cerebro-spinal fluid is from the ventricles within the cisterna at the base, thence through the cleft in the tentorium outward over the surface of the brain into the subarachnoid spaces. The cause of this flow is the force excited by the secretion in the plexuses aided by gravity and pulsation in the brain and a lower pressure in the dural sinuses than in the subarachnoid spaces.

This normal circulation of the cerebro-spinal

fluid may be interfered with by a number of factors, but we are only concerned here with those caused by acute injuries. 90 to 95% of all severe head injuries, with or without fracture, sustain damage to the brain itself or to its coverings. This injury may vary from mere contusion of the contents, rupture of small vessels in the meninges, or brain substance, and minute hemorrhages here and there, to massive extravasation of blood and brain laceration.

The brain is inclosed in inelastic and tough membranes and an unyielding bony case. The only exit of consequence is through the foramen magnum against the walls of which the medulla with its vital centers is gradually forced in certain instances of increasing intra-cranial pressure if unrelieved.

The mechanism of increased intra-cranial pressure or traumatic oedema begins at the time of injury. There is first a dislocation of the vessels, then retardation of the current, followed by extravasation of their contents. This is aided by whatever hemorrhage may be present either outside or underneath the meninges. Cells deprived of oxygen absorb fluid, causing them to swell. The outer coverings of the brain being unyielding, the subarachnoid space is the first to suffer. This being the main channel for the normal escape of cerebro-spinal fluid. On its way to absorption its loss causes a damming back or pooling in the large cisterna at the brain base, below the tentorium. The cerebro-spinal fluid continues to be secreted in the ventricles and pools in the cisterna forcing the medulla upward. This tends to occlude the narrow subarachnoid spaces in the incisura tentorii and further stasis occurs. Normally the blood pressure is greater than the intercranial pressure. If the intercranial pressure increases to a point equal to the blood pressure there will result a cessation of circulation through the brain. This stasis in the brain calls upon the centers in the medulla and the blood pressure rises sufficiently to force blood through the cerebral vessels again. This in turn causes an increase in the condition of stasis already existing in the brain. Such a period is spoken of as the period of medullary compensation. Again there is a corresponding rise in blood pressure. This continues until the medullary centers are exhausted and a condition of medullary exhaustion supervenes and the patient passes away.

This cycle must be broken at a point below the tentorium early enough to prevent death or even

\*Read before the meeting of the Staff of St. Luke's Hospital, Jacksonville, March, 1926.



should death not occur and the pressure be allowed to remain, degenerative changes take place in the cortical cells with a resultant gliosis.

This also explains why many patients pass away even following a large well-performed craniotomy for the relief of pressure. Upon opening the dura and arachnoid there is a sudden gush of fluid. The brain seeking relief from the pressure within is gradually rolled outward, until it fits snugly against the edges of the bony opening. The subarachnoid space is again closed and favorable conditions for the increase of pressure are again present.

Spinal puncture is the ideal method for the relief of intra-cranial pressure from acute trauma as it gives relief below the tentorium, breaking the cycle early, before the later changes are allowed to occur.

Every case of acute trauma should be punctured to determine the spinal pressure. There should be a careful physical examination and a fundus examination, though the fundus does not ordinarily show changes for six hours following injury. Some sort of mechanical means for accurately and uniformly estimating the spinal pressure should be used. The estimation of spinal pressure by counting the rapidity of the escaping drops is most inaccurate.

Under novocain or gas anesthesia, in the lying position, the needle is inserted and without allowing any fluid to escape the mercurial manometer is connected and a reading taken. From 10 to 25 c.c.s. are slowly removed. This will lower the high pressures one-half and bring the lower pressures to nearly normal. Depending upon the indications, regardless of whether the case has been decompressed or not the puncture is repeated at from 8 to 48-hour intervals until the pressure remains normal.

Indiscriminate spinal puncture on all comatose patients or those in whom the diagnosis is uncertain is to be heartily condemned. To remove fluid where there is a block between the ventricle and the cisterna means the patient will die in about six hours or sooner of respiratory paralysis. The habit some surgeons have of operating every case of fracture of the skull is to be condemned. In all head injuries there should be the closest cooperation between the neurologist, radiologist and surgeon.

There has been an attempt made to lay down a hard and fast rule that when the pressure goes above 16 m.m.s. of mercury, a decompression in

addition should be done. This cannot be relied upon absolutely as we have seen much higher pressures respond to the above treatment alone.

We must realize that lost or destroyed structures cannot be restored. What we attempt to do is to prevent more injury than already exists.

We present a summary of a few cases selected from over one hundred cases of skull fracture treated by us during the past four years. Please note that this communication is preliminary to a more complete paper which we hope to present at an early date. We are collecting a series of X-ray films which will be presented at that time.

J. M., male, age 39. Injured in automobile accident. Admitted unconscious and in extreme shock, bleeding from ears and nose. Respiration, shallow and irregular. Decompression under novocain. Eight hours after injury, 20 c.c.s. of bloody fluid was removed by spinal puncture, no pressure. Nine hours after injury the patient became conscious and somewhat rational. Upon admission the patient's blood pressure was 70 over 60. One hour after puncture the blood pressure was 120 over 60. The patient's mental condition continued bad and seven days after injury another spinal puncture was done. 30 c.c.s. of cloudy fluid was removed, under pressure. Mental condition improved rapidly. Fourteen days after injury 20 c.c.s. of fluid was removed under heavy pressure. Seventeen days after injury 15 c.c.s. was removed. The patient's mental condition improved rapidly and he left the hospital four weeks after injury. He has since gone on to a complete recovery.

E. L. S., male, age 40. Injured in automobile accident. Conscious but mentally cloudy. X-ray showed a spicule of bone,  $\frac{3}{4}$  of an inch by  $\frac{1}{4}$  of an inch depressed into the brain in the right parietal region. This was removed under novocain anesthesia. Blood pressure, upon admission was 94 over 60, pulse 86. Twenty-four hours after injury, 22 c.c.s. of blood tinged fluid was removed under pressure. Mental condition improved. Three days after injury 20 c.c. of cloudy fluid removed under pressure. Five days after injury 10 c.c. of clear fluid removed under pressure. Mental condition improving. Eight days after injury 3 c.c. clear fluid removed. The patient's mental condition became normal and he was discharged three weeks after injury.

A. W., male, age 65. Automobile accident. Admitted conscious, blood pressure, 122 over 68. X-ray showed depressed circular fracture, two

inches above right auditory meatus. Decompression under ether. Complaints of headache. Five days after injury 10 c.c. cloudy fluid removed under pressure. Patient improved rapidly and was discharged sixteen days after injury.

R. S., male, age 25. Automobile accident. Admitted conscious, blood 120 over 70. X-ray showed crack half-inch long in the left mastoid which communicates with the auditory canal, bleeding from ear. Mental condition irritable and confused. Five days after injury 20 c.c. cloudy fluid removed under pressure. Patient improved rapidly, up and about after fifteenth day. Discharged on the 23rd day.

S. H., male, age 28. Struck with a heavy wrench. X-ray showed linear fracture contra coup above right orbit. Admitted conscious, blood pressure 100 over 80, not operated. Twenty-four hours after injury 32 c.c. fluid removed under heavy pressure. Mental condition improved. Twelve days after injury 40 c.c. clear fluid removed under pressure. Discharged in good condition twenty days after injury.

C. B., colored boy, age 5. Automobile accident. Admitted unconscious, bleeding from nose and left ear. Pulse feeble, respiration apparently suspended. X-ray showed a three-inch linear fracture in the left occipital region. Immediately after admission, 20 c.c.s. of bloody fluid removed under high pressure. One minute later respiration was restored and pulse became regular. This patient was injured in front of St. Luke's hospital and was apparently dead when brought to the accident room. His condition continued to improve and he made a complete recovery in about three weeks.

B. S., male, age 16. Automobile accident. Admitted unconscious, blood pressure 118 over 70. X-ray shows a linear fracture in the right frontal region above the orbit. No operation. Eight hours after injury 30 c.c. of bloody fluid removed under pressure. The patient rapidly regained consciousness and made an uneventful recovery. Left the hospital on the twelfth day after injury.

H. E. C., male, age 29. Automobile accident. Admitted unconscious, bleeding from nose and ears. Had a large depressed fracture of the frontal bone. Blood pressure 90 over 60. Decompression under novocain. Six hours after accident 30 c.c. of bloody fluid withdrawn under pressure. Patient improved, became conscious and asked for water. Twenty hours after injury 25 c.c. of bloody fluid removed under pressure.

Patient died 22 hours after injury. Note the marked improvement immediately after first spinal puncture; however, there was too much confusion of the brain substance for a continued function of the central nervous system.

J. H. W., male, age 40. Struck by a heavy plank on the right side of head just above the ear. X-ray showed a fracture two inches long above the orbit. Admitted unconscious, blood pressure 126 over 70. Operation, none. Six hours after injury, 28 c.c. of bloody fluid removed under pressure. Patient became partially conscious in one hour after puncture. Eleven days after injury 10 c.c. clear fluid removed. Mental condition rapidly clearing up. Discharged from hospital in normal mental condition four weeks after injury.

L. M., male, age 32. Gunshot wound of scalp in left occipital region. Large amount of brain substance involved in injury. Patient admitted unconscious, blood pressure 86 over 54. Twenty-four hours after injury 25 c.c. bloody fluid removed under pressure. Still unconscious. Forty-eight hours after injury 28 c.c. of bloody fluid removed under pressure. Marked improvement. Fifty-four hours, spinal puncture repeated, 24 c.c. bloody fluid removed. Patient showed immediate improvement, but still in very bad condition. Seventy-two hours after injury 25 c.c. of bloody fluid removed. Patient showed a marked improvement after each puncture, but relapsed within a short time. Patient died on the fourth day.

T. H., female, age 20. Automobile accident. Patient admitted unconscious, bleeding from the nose and ears. X-ray showed fracture in the left orbit extending posteriorly. Twenty-four hours after injury 20 c.c. clear fluid removed under pressure. Patient has become conscious. Five days after injury 15 c.c. of clear fluid removed under no pressure. Eleven days after injury 25 c.c. of clear fluid removed, no pressure. Patient has complained of severe headaches. Patient discharged from the hospital, walking on the fifteenth day after the accident.

In a general summary of these cases, we wish to call attention to the rapid return of the blood pressure toward normal following spinal puncture. In practically all of these cases the blood pressure, both systolic and diastolic is abnormally low. The return in most cases is accomplished in a very few minutes, while in others it takes several hours.

Attention is also called to the general improve-

ment in the pulse and respiratory rate. In the case of the five-year-old colored boy, respiration had ceased, and returned immediately upon relieving the pressure by puncture. We wish also to call attention to the short convalescent period in patients treated by spinal puncture. Also please note the short time required for these patients to return to their normal mental and physical condition. We are sure that cases unrelieved by spinal puncture will have a much longer period of convalescence.

In conclusion we do not advocate spinal puncture as a cure-all, but it is firmly believed that its more extensive use in selected cases will prevent the most serious complication of cerebral oedema which if unrelieved either results in death or permanent brain damage or gliosis, with the subsequent complaints, such as headaches, mental dullness, change in disposition and character and a train of symptoms ascribed to neurosis.

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#### STATE NEWS ITEMS

Doctor J. R. Bean of the State Board of Health recently underwent an operation at the Johns Hopkins Hospital, Baltimore, Maryland. His condition at the present time is very critical.

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Doctor Jack Halton of Sarasota has recently returned home after several weeks spent in the north.

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All members of the Association will learn with pleasure that the wives of the members attending our recent meeting in Gainesville organized a Ladies' Auxiliary. They expect to be quite active in aiding the Association work and particularly in making the social and scientific programs of our annual meetings more attractive. The following officers were elected: President, Mrs. W. Lassiter, Gainesville; vice-president, Mrs. A. H. Freeman, Ocala; corresponding secretary, Mrs. G. C. Tillman, Gainesville; secretary-treasurer, Mrs. M. M. Hannum, Eustis.

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Dr. J. C. Davis, Jr., of Quincy, Florida, was appointed as delegate to the Georgia State Medical Association by Dr. J. S. McEwan, President. Dr. Davis attended the Georgia State Medical

Association meeting at Albany, Georgia, where he received a wonderful reception.

---

The fraternal delegates from Georgia attending the Gainesville meeting were Dr. B. H. Minchew, of Waycross, and Dr. George L. Touchton, of Savannah. It was a real pleasure to have these delegates sit with us in our fifty-third annual meeting of the Florida Medical Association.

---

Doctor H. Mason Smith, our recently elected President, visited Jacksonville following the Association meeting in Gainesville and conferred with the newly elected officers and some of the members of the committees.

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Dr. J. Maxey Dell, Major M. R. C., has recently returned from Anniston, Alabama, where he spent several weeks in military training.

---

Dr. and Mrs. R. R. Killinger of Jacksonville are celebrating the arrival of a fine son.

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Dr. J. Lee Kirby-Smith of Jacksonville has just returned from three months abroad. He visited Belgium, Germany, France, Holland and England. During his stay in London, Doctor Kirby-Smith was invited to address The Royal Society of Tropical Medicine on the subject of "Creeping Eruption." His recent investigations in this particular malady have won for him International reputation.

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The quarterly meeting of the Second District Medical Society was held recently in Chattahoochee and a splendid program was enjoyed. A paper was read by Dr. J. B. Brinson of Monticello on "Pyelitis in Infancy and Childhood." Dr. B. A. Wilkinson of Tallahassee read a paper on "The Use of Magnesium Sulphate in Convulsive States." Doctor S. E. Wilhoit of Quincy presented a paper, and a paper on "The Present Status of the Treatment of Pneumonia" was read by Dr. H. C. Sauls of Atlanta, Ga. This was followed by a clinic by the staff of the State Hospital. Supper was served at 7 p. m., followed by a dance at 8 p. m., music being furnished by the State Hospital orchestra. A very interesting and profitable meeting was the report of every one who attended.



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2 .....	3 to 4 .....	7
3 .....	4 to 5 .....	7
4 .....	5 to 6 .....	6
5 .....	5 to 7 .....	5
6 to 9 .....	6 to 8 .....	5
9 to 12 .....	7 to 9 .....	5

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## PROBLEMS IN NEUROLOGICAL SURGERY\*

CHAS. E. DOWMAN, A.B., M.D., F.A.C.S.  
Atlanta, Georgia.

It is only within comparatively recent years that so-called surgical specialties have been developed. The youngest of these children of general surgery is neurological surgery—so young in fact that it is only within the past ten or fifteen years that its legs have become strong enough to permit a more or less independent existence. It is therefore quite proper for the medical profession to be kept informed concerning the problems and progress of this rather new line of surgical endeavor, as only by its works can its existence be justified.

It is quite true that intracranial tumors play a rather prominent role on the neurosurgical stage, yet there are other actors of considerable prominence who deserve more than a passing notice. For example, in three hundred and thirty-six potential neurosurgical cases studied during the year 1925 there were only forty-five cases of brain tumor. It is gratifying to note that only one of these cases had become totally blind at the time of admission to the hospital, a fact which speaks well for the diagnostic alertness of the present-day physician, for it has not been many years since a rather large number of such patients became totally blind before the true nature of the underlying lesion was even suspected.

The diagnosis of brain tumor is not such a difficult matter as many physicians imagine. An expanding lesion within the cranial cavity usually produces sooner or later an increased intracranial pressure of sufficient degree to give rise to definite symptoms, such as headaches, disturbance of vision due to edema of the optic discs, vomiting, generalized convulsions, drowsiness, mental dullness, and diplopia. The time of development of one or more of these symptoms will depend largely upon whether or not the passages through which the cerebrospinal fluid circulates are encroached upon early or late in the disease. It is thus possible for a tumor of the cerebrum to develop to an enormous size before giving rise to

pressure symptoms; whereas a tumor located below the tentorium, through an early obstruction of the cerebrospinal fluid circulation, will usually produce early in its development an internal hydrocephalus with its attending symptoms.

When tumors are so located as to disturb brain areas of known function, either by direct involvement or by pressure, one can usually make a fairly accurate localizing diagnosis. This is frequently possible before the development of the distressing symptoms of increased intracranial pressure. It becomes, therefore, a matter of paramount importance for every physician to at least suspect the possibility of brain neoplasm in all cases presenting the gradual development of symptoms pointing to brain involvement. When this becomes the rule instead of the exception, these unfortunates will have a greater chance of improvement by the early institution of the proper treatment.

Unfortunately a certain percentage of tumors develop in the so-called silent areas of the brain, and do not manifest themselves until general pressure symptoms develop, and can not be localized by the usual diagnostic methods. Ventricular air injections followed by roentgen-ray study may then be resorted to as an additional diagnostic aid. This procedure, however, should not be lightly used as it is not without danger. Grant of Philadelphia collected the experiences of some twenty-two neurological surgeons and found that in a series of three hundred and ninety-two cases so studied, there was a mortality of eight and one-tenth per cent. One might justly argue that in a condition of such gravity as cerebral neoplasm, a diagnostic method with even a higher mortality incidence is entirely justifiable. I agree entirely with this stand, at the same time I would insist that ventricular air injections be reserved absolutely for those patients in which all other diagnostic methods have failed to give a reasonably accurate localization.

I fear that the medical profession has not been well informed in regard to the merits of the present-day methods of treating intracranial tumors. Before touching briefly on this phase of the subject I would like to sound a note of warning against the all too prevalent practice of institut-

\*Read by invitation before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.



under the frontal lobe and allowed to escape through the lower angle of the wound. Such drains should be removed in twenty-four hours.

*Class E.*—Definite evidence of brain injury without rapidly increasing intracranial pressure, yet of a type which experience has shown is liable to develop within a few days an increased intracranial pressure due to fluid accumulation. Approximately fifty per cent of all head injuries will fall into this group. There are usually more or less linear fractures on X-ray study, blood in the spinal fluid, altered superficial and deep reflexes, etc. The blood pressure remains normal, there is very little alteration in the pulse rate, and the unconsciousness is not deep. There is frequently terrific restlessness. These cases unquestionably have definite widespread brain contusion with a moderate degree of subarachnoid hemorrhage. An immediate operation is not indicated. If treated along the usual conservative lines many such cases will develop within a few days marked increased intracranial pressure due to a subdural accumulation of fluid. If such a condition is allowed to develop, late operation for release of the fluid may have to be done. We are thoroughly convinced by our own experience that such a condition can be prevented and all operations avoided if these patients are put on a so-called hypertonic treatment as soon as properly classified. The treatment which we use is as follows: When the patient can swallow and is not vomiting, he is given one-half ounce of a saturated solution of magnesium sulphate without water every two hours for the first twenty-four hours. The time of administration is then lengthened to every three hours for a day or so, the intervals being gradually lengthened until by the tenth day the drug is withdrawn entirely. Fluids in the form of glucose lemonade and orangeades, salty broths, etc., are given between administrations of the magnesium sulphate. When oral administration is impossible, three ounces of magnesium sulphate dissolved in six ounces of water is given by rectum every twelve to twenty-four hours. If neither oral nor rectal administration is possible ten cubic centimeters of a ten per cent solution of chemically pure magnesium sulphate is given intravenously every four hours for six doses, after which the oral administration can usually be used. It has been proven both experimentally and clinically that the magnesium sulphate will increase the tonicity of the blood to such an extent as to cause fluid

from the various cavities (particularly the cranial cavity) to be withdrawn, as it were, in order to restore the blood to an isotonic state. In this way the late development of increased intracranial pressure in this particular type of case is prevented and the patients go on to uneventful recovery in almost every instance.

*Class F.*—So-called "concussion". The term concussion has been very loosely used and should be reserved for those cases which may be rendered temporarily unconscious as the result of a blow on the head, but in which repeated and thorough examinations fail to reveal any evidence of actual brain injury. An observation of three days will usually permit one to determine definitely whether there has been actual injury to the brain.

*Class G.*—Simple depressed fracture with no symptoms whatsoever and no evidence of underlying brain contusion. We feel that it is safer to elevate such fractures and inspect the underlying brain for contusion, which if found will place the patient in Class C.

*Class H.*—Scalp lacerations with no evidence of fracture or brain injury. Such cases should be thoroughly treated according to the principles of debridement, the underlying skull inspected, and the wound carefully sutured.

The proof of the pie is in the eating. In some three hundred cases of actual brain injury handled by my associates, Drs. Weaver and Cochran, and myself during the past four years, the mortality has been between eighteen and nineteen per cent. With a very few exceptions the patients who died had sustained massive injuries and no rational treatment could be applied. In the whole series there were only some sixty-five operations. The majority of the cases fall into Class E and of these there was only one death, this being caused by an edema of the lungs six days after injury. We feel that this comparatively low mortality is due to our attempt to place each case in the proper class, and to the application of the type of treatment which experience has taught us best suits the individual patient.

*Epilepsy.*—All epileptics deserve a periodic neurological survey, particularly those who developed epileptic attacks in adult life. In the review of any large series of cases of brain tumor one will be surprised to learn that in a great many such cases the only symptoms for months or years were generalized convulsions simulating

closely the attacks observed in genuine so-called idiopathic or essential epilepsy. I have recently operated upon three cases of gliomatous cyst of the frontal lobe in which there was a history of epileptiform attacks dating back fifteen, nine and three years, respectively.

Of even greater interest and deserving if possible even more serious consideration are the cases of focalized or jacksonian epilepsy. Such cases have unquestionably some lesion—macroscopic or microscopic in size, involving some particular area of the brain. We have recently had occasion to review the records of eighty cases of jacksonian epilepsy occurring in my own practice during the past six years. We have found the etiology in these eighty cases to be as follows:

1. Brain tumor .....	20 cases
2. Hemiplegia in children, due to hemorrhage in the internal capsule..	12 cases
3. Syphilis of the nervous system....	11 cases
4. Post-traumatic (adults).....	10 cases
5. Birth injury (children).....	4 cases
6. Traumatic cyst of brain.....	4 cases
7. Post-encephalitic .....	6 cases
8. Acute cortical encephalitis.....	1 case
9. Cerebral arteriosclerosis .....	2 cases
10. Undetermined .....	10 cases

From the record, the principal causes of jacksonian epilepsy in the order of their frequency would be: brain tumor, brain injury, spontaneous internal capsular hemorrhage in children, syphilis, encephalitis, and cerebral arteriosclerosis. One should, therefore, keep these possibilities in mind whenever there presents itself a case of epilepsy with focalized manifestations. With the exception of those cases caused by internal capsular hemorrhage, syphilis, and cerebral arteriosclerosis, exploratory craniotomy over the site of the suspected lesion should always be done. In this way only can many removable lesions be verified and treated. Should exploration fail to reveal a gross lesion, the cortex may be stimulated with a mild faradic current in the search of the so-called epileptic zone. Usually one can demonstrate such a zone, the stimulation of which will throw the patient into a violent epileptic seizure. This zone is considered the particularly irritable area in which the attacks start, and can then be treated with excision (Horsey) or by the injection of alcohol (Dowman)—the purpose being thereby to de-

stroy the localized sensitive area. It is interesting to note that the localized paralysis produced by excision or alcohol injection are of only temporary duration, the surrounding centers gradually assuming the function of the area thus destroyed. Although patients thus treated are not all entirely relieved of attacks, there has been sufficiently gratifying improvement to warrant the continued use of this method of treatment.

*Spinal Injuries.*—Fracture-dislocation of the vertebrae frequently causes such grave injury to the spinal cord as to preclude any improvement in the distressing paralysis, regardless of the type of treatment employed. In the past it has been generally agreed that laminectomy does no good in cases giving evidence of a complete physiological lesion of the cord, whereas cases of partial paralysis were subjected to operation. Since the recent contribution of Coleman of Richmond the decision as to operative interference depends upon other factors.

Unless there is actual spinal cord compression, laminectomy combined with a free opening of the dura is not indicated, regardless of the evidence of complete or partial cord lesion. The object of laminectomy is to relieve pressure. After the usual neurological examination a lumbar puncture is done and the pressure recorded by means of a simple glass tube manometer; bilateral jugular compression is then made; if no spinal obstruction exists there will occur an immediate rise in spinal fluid pressure with a prompt fall to the original level on release of the jugular compression. If on the other hand a complete obstruction is present jugular compression will not cause a rise in the spinal fluid pressure below the level of the lesion. If the obstruction is partial the rise in pressure will be gradual and the fall when compression is released will be slow and step-like—the fluid level being higher than that originally observed. When the evidence is in favor of partial or complete obstruction of the spinal canal an immediate laminectomy should be done. If no obstruction is present the test should be repeated at least once every twenty-four hours for several days as there may develop an obstruction several days after the accident. Eventual recovery in such cases naturally depends upon the degree of actual destruction of the spinal cord.

The care of the bladder in patients of this type is a problem of much difficulty. Repeated catheterization leads eventually to an ascending pye-

litis and death. Allowing the bladder to overflow in the hope of the return of automatic vesical contractions is unsatisfactory. Our own difficulties in the matter have been solved by the institution of suprapubic drainage by means of a mushroom (Pezzer) catheter. The technic of this procedure has been so developed by Dr. M. L. Boyd of Atlanta, as to permit a continuous or intermittent drainage of the bladder with no soiling whatsoever. The infection is thereby controlled, the patient is comfortable, and should normal function return the tube can be easily removed with prompt healing of the fistula. I strongly advise all of you to adopt this valuable measure in all cases of urinary obstruction or paralysis.

*Spinal Cord Tumors.*—No more brilliant results are to be had in the whole field of surgery than those obtained in many cases of spinal cord tumor. The extra-medullary tumors are those most frequently found and can usually be completely removed. After removal the various paralyses usually disappear and the patients are able to resume their normal existence.

The matter of diagnosis is all important. The gradual appearance of progressive motor and sensory paralysis, preceded frequently by pain along the distribution of the posterior roots at the site of the lesion is the most significant history. Valuable aids in arriving at a correct diagnosis are the presence of a xanthochromic spinal fluid, the evidence of partial or complete spinal canal obstruction either with the method of jugular compression, or by comparative pressure readings on simultaneous cistern and lumbar punctures supplemented by the determination of the globulin content of the fluid obtained above and below the suspected lesions. The localization of the lesion depends largely upon the distribution of root pains (if such have been present), the upper level of sensory disturbance, and when an obstruction has been demonstrated, the injection into the spinal canal of lipoidol. This liquid is a combination of iodine in oil, and when injected will gravitate to the level of the obstruction. X-ray studies will reveal a shadow of the solution, thereby furnishing valuable information regarding the exact location of the tumor.

*Posterior Root Section and Cordotomy.*—The neurological surgeon is occasionally called upon for some measure which may relieve patients of intractable pain which resists all other efforts.

Among such conditions may be mentioned painful recurrent amputation neurofibromata, intractable post herpes zoster pains, the painful visceral crises of tabes dorsalis, pains which result from the involvement of nerve roots by malignant growths, etc. Where the lower extremities are involved the operation of cordotomy as recommended by Spiller and Frazier is productive of absolute relief from pain. The operation consists of a high thoracic laminectomy and the cutting (with especially devised instruments) of the anterolateral tracks in the spinal cord. These tracks convey the pain and temperature sense fibers from the contralateral side. A division of these tracks, therefore, will stop all painful sensations from the area below the section without interfering with the sense of touch or the motor power. When the pain is located in certain limited areas supplied by one to three posterior sensory roots, an intrameningeal division of these roots is usually attended by highly satisfactory results.

*Tic Douloureux.*—The pain of true trifacial neuralgia is a characteristic one. It occurs in paroxysmal attacks of agonizing pain, often with intervals of relief for many months, localized in those areas supplied by one, two or all three branches of the trigeminal nerve. Alcohol injection or avulsion of the affected branches will give temporary relief for nine to fifteen months as a rule. The second application of such treatment is followed by a shorter period of relief, until eventually the only logical method of treatment is the so-called radical operation. This consists of the division or avulsion of the sensory root of the gasserian ganglion. This operation, in the hands of those thoroughly trained in such a delicate procedure, results in a complete and permanent relief of the symptoms, and is attended by practically no mortality.

It is rather unfortunate that a clear conception of the splendid results possible in such a distressing clinical entity is not more prevalent. When one remembers that in true trifacial neuralgia the pain does not spread beyond the distribution of the fifth cranial nerve, many mistakes in diagnosis will be avoided and the proper treatment in typical cases will be applied earlier. A careful differentiation should be made between typical tic douloureux and certain atypical neuralgias in which there seems to be an associated disturbance of the sympathetic system. The pain in these atypical cases spreads over areas



not supplied by the fifth nerve, and no surgery on the fifth nerve will give relief. The so-called "lower-half headache" described by Sludder is an illustration of atypical facial neuralgia. Alcohol injection of the sphenopalatine ganglion seems to give relief in some of these cases.

The character of pain in glossopharyngeal neuralgia is similar to that observed in trifacial neuralgia except in distribution. The pain in such a condition is principally in the pharynx, in the region of the faucal pillars, and is often referred to the ear. Compared to tic douloureux it is uncommon. An intrameningeal section of the glossopharyngeal nerve seems to give permanent relief.

*Peripheral Nerves.*—Prolonged waiting in the hope that traumatized nerves will resume their function should be discouraged. It is far better to explore an intact nerve than to overlook for many months one which has been severed. During the period of paralysis much damage is going on in the paralyzed muscles. When nerve sutures are done late, therefore, the results will probably be poor; not that regeneration in the nerve does not take place, but rather that the muscles themselves have undergone fibrosis and fatty degeneration, and few viable contractile elements remain to receive the stimulation through the regenerated neurons. The earlier nerve sutures are done, the better the results. Should it seem advisable to wait, three months should be the maximum. In the meantime, daily manual massage and the support of the paralyzed muscles should be given. Even after the nerve suture has been accomplished similar measures should be practiced. In other words, the paralyzed muscles should be kept in such condition as to prevent as far as possible a permanent degeneration of the contractile elements. When properly handled, nerve sutures are usually attended by excellent results. The method of suture is all-important. Stay sutures through the nerve itself should be avoided, and the approximation should be brought about and maintained by means of fine silk sutures in the nerve sheath. Complete hemostasis should be assured, as a small hematoma between the approximated nerve ends will promote fibrosis, which in turn will interfere with the regenerating neurons in their descent into the distal portion of the divided nerve.

There are many other phases of neurological surgery which can not be discussed at this time.

as already, I fear, your patience has been overtaxed. The method of handling the hydrocephalic child, spina bifida, abscess of the brain, spasticity of childhood, Raynaud's Disease, spasmodic tortocollis, injuries of the brachial plexus, etc., present many interesting problems. It has naturally been out of the question to do more than skim the surface, as it were, in order to leave the impression that the problems of neurological surgery are those of everyday practical interest. Much has already been accomplished and if I dared utter a prophetic note I would predict that the future will see the solution of many problems of the nervous system which at the present time wear a sphinx-like countenance.

#### CHOLECYSTOGRAPHY\*

JOHN E. BOYD, M.D., F.A.C.S.  
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The discovery in 1919 by Abel and Rowntree that phthaleins and their derivatives when injected subcutaneously were excreted only in the bile opened the way to visualization of the gall-bladder.

In 1923-1924 H. A. Abramson, experimenting with dogs, injected neo-silvol in amounts of 1 c.c. of a 35% solution directly into the gall-bladder. Excellent photographs were obtained. He found that the presence of pneumoperitoneum, whether operatively or artificially produced, aided in the visualization.

Early in 1924 Everts A. Graham, M.D., and Warren H. Cole, M.D., of St. Louis, Mo., undertook to prove that the gall-bladder could be visualized by the X-ray providing the following requirements were met:

"(1) It must be a substance which could be introduced by injection subcutaneously or intravenously or could be given by mouth.

(2) This substance must be something which would be excreted almost entirely by the bile, and, further, into the gall-bladder.

(3) It must be a substance which would not be toxic in the proportion necessary to produce a shadow."

The extensive use of various dyes in the search for a suitable test of the liver function revealed the fact that some are excreted almost entirely into the bile, viz: tetrachlorphenolphthalein and rose bengal. From this fact a similarity of chemical structure lead to the use of tetraiodophenolphthalein and tetrabromphenolphthalein.

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Satisfactory shadows were obtained in both instances.

As much as *eight* atoms of the iodine was substituted for the *four* atoms of chlorine, but unfortunately the octoiodophenolphthalein proved too toxic for use; the octobromphenolphthalein also proved too toxic.

In the early experiments very poor shadows were obtained in some cases and a change to the calcium salt was made. It was later found that the fault lay, not in the salt, but in the fact that these particular cases had food in their stomachs or duodenum. With this explanation the difficultly soluble calcium salt was promptly discarded. In the use of the sodium tetrabromphenolphthalein the dose, approximately 5 gm., is dissolved in 40 c.c. of distilled water. This solution is then given in 20 c.c. amounts at half hour intervals necessitating the puncturing of the vein twice. It also requires that a teaspoonful of sodium bicarb. be given every three or four hours following the injection. The need for this is based on the theoretical ground that the presence of the bicarb. in considerable quantities in the stomach tends to close the sphincter of Oddi and so prevent the emptying of the gall-bladder. Using the sodium tetraiodophenolphthalein the dose, approximately 3.5 gms., is dissolved in 100 c.c. normal saline solution. To this is added 1.5 to 2.0 c.c. of 10% solution of sodium carbonate to keep the salt in solution. This solution is autoclaved for thirty minutes at 15 lbs. pressure. At the time of injection normal saline is added to make a 1 or 2 per cent solution which is given slowly at one injection.

The best shadows are obtained in normal individuals.

As early as February, 1925, Graham & Cole stated it was possible that the toxicity of the iodine compound might in part be due to decomposition products. We feel, according to our experience, that this probability has been eliminated. Several companies are now marketing a tetraiodide compound which seems free from impurities and which, they claim, does not decompose. This statement as to decomposition is not borne out in our series.

Sodium tetraiodophenolphthalein has a molecular weight of 682. It is a light blue, crystalline compound which is soluble in water to the extent of at least 40 per cent. The lethal dose in dogs is 0.29 gms. per kilogram of body weight—the same as that for the bromine salt.

Sherwood Moore states that sodium tetrabromphenolphthalein has, in his hands, been successfully given only by the intravenous method, though it has been administered by mouth; also by rectum. By mouth, either through vomiting or diarrhoea, failure has been the result. Early expulsion of the injection lead to failure by the rectal route. The iodine compound is now being successfully used by the oral method.

Before the development of cholecystography roentgenographic examination of the gall-bladder consisted in the demonstration of some cases of stones, poor visualization of a thickened gall-bladder and a few unreliable secondary signs of cholecystic disease. These signs were difficult to elicit and allowed of much uncertainty and difference of opinion.

Moore believes that almost every patient with symptoms of gall-bladder disease should have a gastro-intestinal study with the opaque meal in addition to the investigation of the bile tract with the dye.

Graham, Cole and Copher say that in order to visualize the gall-bladder it is necessary (1) that the liver excrete the dye; (2) that the hepatic, cystic and common ducts be patent; (3) that the gall-bladder have the ability of emptying and filling itself; (4) that the latter, once filled, be of a size to contain a sufficient amount of dye to give a shadow; and (5) that the gall-bladder be able to concentrate the dye.

What cholecystography may reveal in the case of recent or acute disease and in young subjects with vague symptoms, there is, as yet, little data to go on.

Quoting from Graham, Cole and Copher: "In conclusion, I would like to point out that under most favorable circumstances and with meticulous care the usual roentgenographic methods of examination of the biliary tract have been but 47.4 per cent correct over an eight-year period when checked by operation. In our series, so far, cholecystography has been 92.5 per cent efficient.

Doctor W. H. Stewart, New York City, in the use of the bromine compound, notes considerable reaction in many of the cases, some quite severe. The first sign was a flushing of the face followed by headache, nausea, vomiting and faintness. Doctor Stewart says: "The severe symptoms last but a few minutes. Some had a persistent headache and dizziness for twenty-four hours." Recognizing this reaction as the

most serious objection to the method, special attention has been given to its prevention. Improvement has been aided by a more careful selection of the patient. Among those enumerated as poor subjects he mentions "highly emotional and neurotic patients." Our experience emphasizes this statement.

In our series, using the iodine salt only, the first symptom of reaction was invariably "nausea"; immediately followed by increased pulse rate; pallor of the skin and complaint of faintness. Ten to fifteen minims of adrenalin chloride hypodermically relieved the symptoms in one to three minutes.

Russel D. Carman, M.D., of the Mayo Clinic, believes that in the use of the bromine compound reactions are so severe as to be contraindicated in certain conditions. These conditions include—(1) obstruction of the common duct; (2) extensive hepatic disease; (3) marked diabetes; (4) hyperthyroidism; (5) arterio-sclerosis; (6) hypertension and cardiac disease, especially that attended with auricular fibrillation. So far as we can learn this is the first note of warning as to definite clinical contraindications for the test.

Doctors Lester R. Whitaker, Gibbs Milliken and Edward C. Vogt of Boston were the pioneers in the oral administration of a dye in cholecystography. These gentlemen used the iodine compound in place of the bromine. I quote as follows:

"It was found that with the double salol-coated pills a large proportion of them went through the alimentary canal without being dissolved. Even with single coated pills some of them passed through. In spite of this fact, definite gall-bladder shadows were produced in 92 per cent of the normal subjects and 85 per cent of the patients. On the whole, the shadows produced by the oral method were less dense than those by the intravenous method with the iodine salt." These men are now using a pill coated by steric acid. Since the above statement, this method has greatly improved until it has almost excluded the intravenous method in routine examinations.

With our present knowledge of the oral method for cholecystography, we would suggest that patients suspected of having gall-bladder disease *first* be given the drug by mouth. If a normal, clearly outlined shadow which diminishes rapidly in size during digestion is obtained, the probability of gall-bladder disease is slight. If, on the other hand, the shadow is imperfect or absent,

providing the technic has been good, then an intravenous injection of the drug should be made in order to confirm the findings. The one serious objection to this is the matter of added cost.

Whitaker, Milliken and Vogt claim 95 per cent correct diagnosis in their proved cases.

It is now conceded that the iodine salt is a safe drug to use; also that it yields better results than the bromine salt.

Sabatini is experimenting with the alkaline bromides, 20 gm. of bromide of soda and strontium combined dissolved in 100 to 150 c.c. of water, in cholecystography.

He writes: "The remarkable results obtained by this method have been very encouraging; the clearness of the radiograms showing the visible gall-bladder, the advantage of being simple in use and the fact that it does not disturb the patient, suggests the possibility that the bromides will replace other means recently suggested for the same purpose."

The above, at first, sounds most encouraging, but the necessary preparation is very trying and for practical use almost prohibitive. Briefly, two days before the examination the patient is given a light purgative. The next morning he takes bouillon and an egg; at 2 P. M. he takes 1 to 1½ ounces of castor oil; at 5 P. M., a cup of milk. After no nourishment, *not even water*, at 9 P. M., an enema of tepid saline solution. Between 2 and 4 A. M., the bromide solution is given. No food or water is allowed during the time of examination. Radiograms are made five, eight and twelve hours after taking solution.

It has been shown that oil introduced into the duodenum produces a sudden marked change in the size of the gall-bladder shadow. Pituirrin seemed to cause a contraction of the gall-bladder wall, and atropine a relaxation. Boyden has noted particularly the effect of lipoids and fats upon the emptying of the gall-bladder. Sosman, Whitaker and Edson have worked extensively on the effects of various stimuli, including foods and chemicals, on the shadows of gall-bladders. They obtained the most marked diminution of the size and density of the gall-bladder shadow after the ingestion of fats. There was no response to psychic stimuli, carbohydrates, pilocarpin, adrenalin, hydrochloric acid, bile salts, or nitroglycerine. A moderate response was obtained from proteins and magnesium sulphate. Slight paralyzing effects were obtained from atropine and alcohol.



Cholecystography has brought out the interesting fact that the gall-bladder does *not* lie in the gall-bladder region as is set forth by clinicians, or as described in the anatomy.

Doctor Sidney Lange states that in his series of 500 cases the gall-bladder extended either partly or wholly below the lower limits of the hypochondriac and epigastric regions in 75 per cent of the cases. Usually it descends into the umbilical region, but quite frequently into the right lumbar region.

Furthermore, in the 25 per cent of the cases in which the gall-bladder is found above the second lumbar vertebra, that is, in the so-called gall-bladder region, it does not always lie in the line that separates the hypochondrium and epigastrium, but may lie far to the right of this line and may be found outward as far as the axillary margin of the abdomen.

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#### INTERPRETATION OF CHOLECYSTOGRAMS\*

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All authorities are agreed that cholecystography is still too recent to justify any dogmatic statement regarding the interpretation of the X-ray shadows.

It is an established fact that elements are opaque to X-rays approximately in proportion to their atomic weights. The atomic weight of bromine is 80, while that of iodine is 127. Sodium tetrabromphenolphthalein contains 47 per cent of bromine; while sodium tetraiodophenolphthalein contains 59 per cent of iodine.

Theoretically, it should require about 50 per cent as much of the iodine as of the bromine salt to produce the same density of shadow in a radiograph. In actual experiment, in order to produce shadows of equal density, it was necessary to have a depth of solution of the iodine salt of 3.8 centimeters, while that of the bromine salt was 5.5 centimeters.

Graham and Cole of St. Louis state that a normal gall-bladder will begin to cast a shadow three and a half to five hours after the intravenous injection of the dye; that the shadow will show a tendency to change in size; that its heaviest shadow will be cast between sixteen and twenty-four hours, and it will empty in about forty-eight hours. In our series, we have obtained definite shadows of the gall-bladder as early as one hour following injection in several normal cases. The shadow shown on the four or eight-hour films is almost invariably larger than the subsequent shadows. So far, all gall-bladders that failed to show "elasticity or dis-

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tensibility" at some time during the series, the injection being satisfactory, have been proved pathologic by operation, or have given definite clinical findings of gall-bladder disease.

The density of the gall-bladder shadow is dependent on its concentration power. This may be partially or completely destroyed by disease. A failure to cast a shadow is practically 100 per cent proof of disease of the bile passage.

Whitaker of Boston states that food rich in fats produces a marked shrinkage in the size of the gall-bladder shadow. In demonstrating this the Boyden meal is used, viz, the yolks of four eggs and one-fourth to one-half pint of cream. We have obtained good contractions one hour following a cup of cocoa with buttered toast, or a salad rich in salad dressing. It has been reported that the gall-bladder responds markedly to psychic influences and is often emptied by the smell of appetizing odors of foods, especially broiled or fried meats. The enormous reduction in size of the gall-bladder one hour and a half after such a meal indicates that most of the bile has been thrown out through the cystic duct. In a number of cases there was a much more marked reduction in size of the shadow after the taking of food rich in fat than after the intraduodenal injection of magnesium sulphate, as practiced by Doctors Silverman and Menville of New Orleans. This finding, Dr. Whitaker says, reflects a good deal of doubt upon the value of non-surgical biliary drainage by magnesium sulphate. Why subject the patient to the discomfort of a duodenal tube if you can drain the gall-bladder better by giving him bacon and eggs in the morning?

As regards the interpretation of *abnormal* shadows, we feel that there is still much to be discovered. We do feel, however, that we have certain criteria for the establishment of the *normal*. One requisite necessary to normalcy is that the shadow should appear fairly early, i.e., there should be a good shadow by the end of the fourth or fifth hour with the intravenous method and by the twelfth hour by the oral method; again the edge of the gall-bladder shadow should be regular and of fairly normal contour; further, the gall-bladder should show a strong capacity for emptying itself.

As to gall-stones, the evidence usually presents itself in either of two ways. Some stones become denser by the dye coating, while others, which are usually classed as negative stone shadows,

show within the gall-bladder shadow as a mottling by a displacement of the dye.

Some cases indicate that the observations of the late Dr. Walter Mills of St. Louis concerning the relationship of bodily habitus to the form, function and tonus of the alimentary canal, applies with equal force to the gall-bladder. Following this out, each type of habitus should have a characteristic gall-bladder. For example, the asthenic should show a long, laterally narrow organ in a low position in the abdomen, whereas the sthenic individual should show a shorter, wider, in fact, circular shadow close up under the costal margin. Intermediate types will show characteristics in between these extremes.

Graham, Cole and Copher, of St. Louis, say: "I believe we are too greatly influenced in our efforts at interpretation by the findings in other organs. We expected to find deformity of outline, filling defects, localized variation of shadow intensity, intensification of gall-stone shadows present or suspected, impression of adhesions, etc.; in point of fact, few or only suggestive evidence of any of these have occurred in our material. Even a cursory examination of gall-bladders excised supplies the reason why this is so. They are so extensively diseased that but little of the injected dye could reach the organ. Its concentration in such an organ would be impossible. As to distortion of outline by adhesions, it may be laid down as almost *axiomatic* that adhesions about a hollow viscus produce such results only in the *rarest* of instances. Adhesions *fix an organ*, occasionally they displace but only *exceptionally* do they deform it. If the gall-bladder possesses peristalsis, adhesions will affect this function, as in other hollow organs, by interference with its conductivity."

It is generally agreed that: (a) if no shadow is obtained in the series, a pathological condition is present in the biliary tract; (b) if the shadow is present, but faint, the hepatic, cystic, and common ducts are patent and the gall-bladder is diseased; (c) if the shadow is present, either faint or intensive, but of uniform size throughout the series, there is present disease of the organ affecting the wall. Persistence of the shadow beyond forty-eight hours has not been encountered enough to justify conclusions.

Gall-bladders giving no shadow and apparently normal at operation have been found, on incision, not only to be diseased but to contain stones.



Whitaker and Milliken of Boston state as follows:

"The conditions indicating pathological gall-bladders have been (1) failure to produce a shadow due to cystic duct obstruction or severe cholecystitis; (2) gall-stones which are not seen in the plain films but show 'negative' shadows in the cholecystograms; (3) failure of the normal expansion and contraction of the gall-bladder; (4) distortion of the shadow due to causes in or about the gall-bladder."

#### CHOLECYSTOGRAPHY\*

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Analysis of the patients studied at our office and in the hospitals by Dr. Shaw and myself, covering all referred cases, shows that we have given the dye (sodium tetraiodophenolphthalein), one hundred and thirty-four (134) times. By the intravenous method thirty-five (35) times; by the oral method, ninety-nine (99) times. Gall-bladder shadows secured by the intravenous method are uniformly good, excluding those patients with deficient liver and kidney function. No shadow, or poor shadows were secured in sixteen (16) cases. This has, at times, diagnostic significance. Again, is due to poor solution and absorption of the dye, and when the patient is studied with the intravenous method, a clean-cut gall-bladder shadow is, as a rule, secured. In three children we essentially secured no shadow (all oral studies). Two patients were given the drug twice orally. Eight patients were given the drug both orally and into the vein. Forty-eight (48) studies were reported as normal. Fifty-six (56) as chronic gall-bladder disease. Ten (10) chronic gall-bladder disease, with stones. Thirty-one (31) patients were operated, and of these twenty-nine (29) showed a confirmation of diagnosis of chronic gall-bladder disease, with and without stones. Operative reports made by the operating surgeon: Two cases, reported as normal, were found at operation to be completely enveloped and sealed over with adhesions, or congenital bands. Subsequent study of the barium meal examination indicates in these evidence suggesting fixation of the duodenal cap. Poor shadows were secured in three cases with the intravenous method, probably due to deficient

liver function. Poor, or faint shadows, were secured by the oral method in seventeen (17) examinations (about 15%), due to nausea, vomiting, purging, poor solution and absorption of the dye in the intestine. Again, possibly due to diagnostic poor filling. Our results with the dye study are exceedingly encouraging. We feel that the so-called "indirect" signs are of distinct value. Fine crenation of the duodenal cap has, in our experience with a few exceptions, been a finding in chronic gall-bladder disease. Marked obstruction of the second portion of the duodenum has indicated chronic gall-bladder disease without stones in three cases seen. Retention and projection of barium in the ampulla of Vater has uniformly been associated with chronic gall-bladder disease. Real, actual pressure deformity of the pyloric bulb and duodenal cap has indicated chronic gall-bladder disease.

#### DISCUSSION

*Dr. John S. Helms, Tampa:*

I wish to express my appreciation for the great historical, scientific and practical value of this presentation. It illustrates, too, the great value of splendid team-work. I have oftentimes cited a quotation, that is, a quotation from others, that the day has come when the practice of medicine cannot be carried out successfully by one individual. The study of the gall-bladder is a splendid illustration of the field wherein it requires team-work, one that should have consulting specialists in the different branches and different phases of the work.

When we are considering gall-bladder disease we must not overlook the fact that we are not studying the gall-bladder alone. The gall-bladder, when it becomes diseased, is not diseased within itself alone. There is associated with all cases of cholecystitis, hepatitis, and oftentimes pancreatitis. We must not overlook these associate organs in the study of gall-bladder disease.

The later methods of the study of gall-bladder disease have given us more or less positive findings with respect to end results of gall-bladder disease—that is to say, gall-bladders that have stones, and gall-bladders that may be closed by fibrous or other pathological conditions. Now, the point the physician is interested in is upon what finally rests the relief of these patients who are suffering from gall-bladder disease—he wants to know some method whereby he will be able to make a diagnosis in the early stages of the disease when he can give the patient

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definite and permanent relief. The surgeon usually sees only the end results of gall-bladder disease, and at that time, the hope for complete recovery of the patient, due to the fact that he has a chronic hepatitis, and probably a chronic pancreatitis, is not so favorable. To add to that, he has an extraordinary operable risk to contend with, whereas, if the diagnosis could be made in the early stages of the disease that operative risk would be very small, indeed, and an ultimate complete recovery of the patient would be assured.

Now, I regard this dye method of cholecystography a very great advance in the study and diagnosis of gall-bladder disease. Graham states that the test is largely a functional test—that is to say, a test of the function and power of the gall-bladder to concentrate bile, and also test the function of the gall-bladder to equalize and maintain a proper pressure with the bile system. Also, it gives some idea of the function of the liver. This is of great value, and if the Internist, Physiologist and Roentgenologist could get together and decide upon some definite standard as to what the gall-bladder function really is, then the test will be of much more value. I think the test bears the same relation, at this time, to the diagnosis of gall-bladder disease as to the opaque meal test bore to the study of the stomach and gastrointestinal tract in the early stages, and that the final outcome of the method will be, perhaps, as perfect, or more perfect than the study of the gastrointestinal tract by the opaque meal method of today.

I think the matter presents a more hopeful aspect. And, I think, that we will have in this an added method of diagnosis that will finally enable us to diagnose gall-bladder disease in its incipency, when the pathology has not grown to that point where final and permanent relief cannot be had, and without a great deal of risk.

*Dr. G. Raap, Miami:*

We must bear in mind the fact that this method of studying the gall-bladder is still in its infancy. I believe those of you who were present at the last State Meeting will recall that Dr. Beals showed us some radiographs which clearly demonstrated that the gall-bladder could be visualized by this method. You may have noticed from Dr. Cunningham's paper that we are not studying the types of shadows that we know—and that is the only severe block in the progress

of this method of examination. We are all enthusiastic about it; we are bound to be, because it is the only method of any great merit that we have in the study of gall-bladder disease. We have to go through the same progress that we went through in the study of the gastro-intestinal tract by use of the barium meal. In the use of the barium meal we are dealing largely with a mechanical sort of thing, but in the use of the dye we have other factors that have to be borne in mind except mere mechanics. Barium is an inert sort of thing, while the dye, or the process by which it is brought into the gall-bladder, is much more complicated than the process by which the barium passes through the gastro-intestinal tract. There are so many factors which have a bearing upon the degree to which the gall-bladder will be demonstrated in the radiograph. The statement was made that practically in 100 per cent of the cases which did not show shadows we may state that there is a pathological condition. I believe that in time we are going to have to change that statement. I don't believe that it is going to hold to the extent of 100 per cent. I have noted a few cases with ulcerations, either of the duodenum or of the stomach, that did not necessarily produce marked adhesions in the area adjacent to the gall-bladder, yet serving as irritating factors, which changed to a considerable extent the degree of radiability of the gall-bladder which had been filled with dye.

One thing I was glad to hear Dr. Cunningham bring out, and that was the point that the dye method justifies many of the deductions that we made before we had that method. We still have to depend to a very great extent upon indirect findings, and it is only in the light of the new method that we have been able to ascertain, for instance, the reliability of such evidence as a fine feathering of the duodenal cap or duodenum as having a definite relation to gall-bladder disease.

I believe that ultimately there is going to be added to the method of dye ingestion or dye injection, some mechanical measure by which we may be able to give a type of dye in which there will be secretion which can be measured, so that if all of it is not secreted into the gall-bladder, we may ascertain where it is going, and why. Of course, that is all going to be advance work along this line.

The statement was also made that providing the technique is perfect we ought to have a visu-

alization in the normal gall-bladder, but in the organic or pathological gall-bladder we may not get a visualization. The burden of proof as to technique rests with the Roentgenologist. But, on the other hand, there has to be a close cooperation between the surgeon, the Roentgenologist and the Internist.

Dr. Helms brought out the point that we hoped by this method to be able to study the early stages of the pathology, and I believe that is going to be one of the real values of this method. We have seen one or two cases in which the diagnosis of pathological gall-bladder was made, but the surgeon hesitated very much before removing the gall-bladder even after he had opened up the abdomen—in contrast to the older surgeon who palpated the gall-bladder and said that it would have to come out. But there have been a few of these cases in which microscopic section showed sufficient pathology to warrant surgical removal. We noticed in a case which was sent to Mayo some time ago, that they would not remove the gall-bladder because they did not feel, from inspection and palpation, that it was pathological, but in some of their recent literature they have stated that they are more and more inclined to remove the gall-bladder, provided the findings by this new method are positive.

As to the amount of dye which will outline a gall-bladder: I had the opportunity of getting two specimens and tried them out, using distilled water as a medium to place the dye in, then injecting the dye into the gall-bladder, which had been removed and tied off at the neck, and I found that it requires a percentage of dye not over 3 per cent to give you a shadow through an equivalent which corresponds to the thickness of the patient, and I have noted in some of them that  $2\frac{1}{2}$  per cent of the dye will show up the gall-bladder. So it goes to prove that we really don't have to get much of the dye into the gall-bladder to produce a shadow, and we may from that infer that if we cannot get even 2 per cent of the dye into the gall-bladder, there must be a sufficient pathology to warrant such a diagnosis.

*Dr. J. C. Dickinson, Tampa:*

I would like to ask one question—if I correctly understood Dr. Boyd to say that this dye had been used in some two or three children, and in each of these cases the gall-bladder was not visu-

alized. Was I correct, and if so I would like to ask if these children gave evidence of pathology and if so, that Dr. Boyd or Dr. Cunningham give some explanation as to why uniformly negative results were obtained in this number of children. If they can enlarge upon that in closing, I think it would be helpful.

*Dr. J. A. Beals, Jacksonville:*

One thing that has impressed me very much in the development of the study of gall-bladder examination by the dye method is this: that the surgeons themselves are not well agreed as to what constitutes a pathological gall-bladder. Therefore, the evaluation of this dye method is in very much the same position as the evaluation of the older methods, and some years ago the evaluation of the gastro-intestinal methods. The surgeons are not always agreed. I would, therefore, like to call your attention to a summary from Dr. Graham, the author, in a way, of this dye method, in which he sets forth in *Radiology* for April, 1926, and gives the criterion upon which he judges a pathological gall-bladder. I realize clearly all of the surgeons might not agree with him as to all of his criteria, but would it not be very well, indeed, in judging this method, if the surgical criteria for the normal and abnormal were set down side by side with the findings by the dye method?

*Dr. J. S. McEwan, Orlando:*

Fellows, that was a very fine paper that Dr. Cunningham and his collaborators read to us this morning, and it is one of the greatest advances in radiography that we have had in some time, and one of the greatest helps to the surgeon in the diagnosis of gall-bladder trouble. We must not lose sight of the fact that we still have our clinical symptoms first, and then we have our radiography, second. If we base our diagnosis on our pictures alone we will go astray most of the time. The pictures must correspond and should correspond with our clinical symptoms, which should come first.

#### CONCLUSION

*Dr. L. W. Cunningham, Jacksonville:*

We might say that in two of these children they had definite evidence of disease in the biliary tract, but we did not feel the urge to punish them any more by trying to give them more dye. One child did not have any evidence of disease of the biliary tract, but a suggestive history. Our

cases of children are limited, and we do not know why we do not secure shadows of the gall-bladder.

The pathological study of the gall-bladder, when removed, is the last word as to gall-bladder disease, or its absence. One of the cases that we saw Dr. Boyd remove the gall-bladder recently—and he was in doubt as to whether it was in trouble, but finally thought it was and took it out—was reported by the Pathologist as a chronic gall-bladder.

Our paper, of course, deals entirely with the question of dye study of the gall-bladder and not of the diagnosis itself or of the patient. We, of course, realize that cholecystography, or other X-ray evidence, must be taken and weighed carefully with all other evidence that you can collect, and that the X-ray does not make a self-supporting diagnosis in this line of work or in any other line of work. It may appear to, but it is wiser to get all of the evidence.

### PROSTATIC HYPERTROPHY\*

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Jacksonville.

Hypertrophy, or enlargement of the prostate in itself, is an innocent disease, but has considerable influence upon the health and comfort of its victim. It is a disease of the declining years of life. That famous English surgeon, Sir Benj. Brodie, once said: "When the hair becomes grey and thin, when there is formed a white zone about the cornea, at the same time, ordinarily, I dare say, invariably, the prostate increases in volume." This, no doubt, is true.

The greatest majority of cases are discovered between the ages of fifty and sixty-five. Though, no doubt, the process of enlargement has been going on for a considerable period of time. However, cases have been reported in middle life, or even younger. One case of the fibrous type, occurring at the age of thirty-two, has come under our observation.

There are two types of prostatic enlargement, classified according to overgrowth of glandular substance, or fibrous tissue. The larger the prostate the greater the amount of adenomatous substance. This type may become very large. We have seen one that weighed one hundred and ninety-two grammes. Dr. Deaver states that they reach the weight of three hundred

seventy grammes, or over. In view of the fact that the average normal prostate weighs about twenty-five grammes, this is considerable enlargement.

The fibrous type does not become very large. In fact, it may be no larger, or even not as large as the normal prostate, but weighs more in proportion than the adenomatous enlargement.

The effects of prostatic enlargement are due to the secondary changes that take place in the urinary tract on account of retention and infection. Retention may be caused by a ball-valve action from enlargement of the middle lobe or by the elevation of the posterior urethral opening above the bladder floor on account of the upward growth of the prostate. The posterior urethra becomes elongated, tortuous and compressed, increasing the degree of obstruction.

The bladder soon becomes a dilated reservoir which is never completely emptied, and this dilation eventually extends to the ureters and kidneys, causing hydronephrosis and renal insufficiency, which is manifested by lowered kidney output and increased non-protein blood nitrogen.

Since the bladder is never emptied, there remains an ideal culture media in the decomposed residual urine for infection to take place, the results of which are cystitis, pyelonephritis and pyonephrosis.

A great many patients with considerable prostatic enlargement are not aware of their condition. They are not inconvenienced in the least by virtue of this enlargement. The degree of enlargement has no bearing on the severity of symptoms, as some of the very large adenomatous prostates are accompanied by less severe symptoms than the small fibrous type.

Patients who are seen in the first stage of this disease usually present themselves because they are inconvenienced by nocturnal frequency of urination. This is the first symptom of prostatic enlargement, due to congestion of the vesical neck rendering the bladder more sensitive to distention. However, there are a great many old men who think it an established custom at their age to arise once or twice during the early morning hours to void and never seek professional advice for this symptom.

The second stage is that of retention without infection. A great many of these are not aware of their condition until they develop a sudden complete retention, usually brought about by undue exposure to cold or as an aftermath of a drinking spree.

\*Read before the Staff of St. Luke's Hospital, Jacksonville, December, 1925.



And, still, there is another type who is well aware of his plight. This is the pitiful old man with all the symptoms of chronic retention and infection who is in the third stage of prostatic enlargement. This is a typical picture.

This is the type of patient we wish to consider in this paper. On account of the age and characteristic symptoms; by rectal palpation with an instrument in the urethra and with the aid of the cystoscope the diagnosis is usually not difficult. However, malignancy, atony of the bladder, prostatic calculi and strictures of the urethra must be eliminated.

Cystoscopy is indicated in nearly every case of prostatic enlargement before an operation is performed. A median lobe enlargement can not be diagnosed without the aid of the cystoscope, but its greatest asset is in ascertaining the intravesical condition and its complications. Diverticula and calculi are not infrequent complications, while recognized by cystoscopy. This is most important where perineal prostatectomy is to be done. Cystoscopy, however, is not without danger in these old men with retention and infection. It should be done with the utmost gentleness and with a thorough understanding of their renal condition. There is considerable trauma with the most careful technique, and the cystoscopist should make his examination as short as possible, else an impending uremia might be precipitated. This is especially true in cases with a great amount of residual urine who have never had urethral instrumentation. Even these patients may be examined with safety at the proper time during their preoperative treatment by an experienced cystoscopist.

We use a small indirect vision cystoscope for these cases. It has a fairly large lens system, since there is no catheterizing apparatus attached. This gives good vision, and at the same time produces the least amount of trauma. It is not possible to catheterize the ureters in some of these; it is very difficult in others and unwise in most of them, as there is very little to be gained. It requires more time and produces considerable more trauma.

Of greatest importance to these old men is what relief can be expected, and in what way may this relief be brought about. Is he to use a catheter the rest of his life or submit to a surgical operation?

If he chooses the catheter life, he not only will be miserable during this time, but will likely die within a few years of renal complications.

We rarely ever see one who uses the catheter practice asepsis or even gentleness. Occasionally, however, we see one who has used a catheter for many years without renal complications. It has been our experience to see many who choose a catheter life return and ask for surgical intervention.

Prostatectomy effects a cure in the greatest majority of cases, is a relief in others and a failure in a very limited number. The results in these cases of retention and infection depend largely upon the condition of the bladder and kidneys; the patient's general condition, the preoperative treatment and the selection of time during this period for operation.

The phenolsulphonephthalein output and retained blood urea and creatinine are our criteria in determining the condition of the kidneys. Since nearly all of these patients with retention and infection have low phthalein output, high blood urea, and who generally are in poor physical condition, we feel that the most important thing in preparing them for operation is the preoperative treatment. First, kidney decompression is done, using the indwelling urethral catheter or by cystotomy. Where there is a large amount of residual urine, gradual emptying of the bladder is imperative. Sudden decompression causes congestion of the kidneys, which may result in complete suppression of renal function and death of the patient.

We are of the opinion that cystotomy should be done even though a catheter is used for the gradual emptying of the bladder. This puts the posterior urethra and bladder at rest, relieving congestion and inflammation.

After decompression is done we begin our eliminative and supportive measures. Fluids are forced to a point of tolerance. Sweating is induced by hot blankets or by the administration of some of the diaphoretics by mouth. Salines are given. The heart is supported by digitalis and normal saline is given under the skin. With these measures, the blood pressure begins to recede, the phthalein output is increased and the blood urea is diminished, as Dr. McIver will develop in his discussion of this paper.

The patient's general condition improves, and though the laboratory reports of phthalein output and blood urea after a considerable period of preoperative treatment are not altogether encouraging, these patients have become tolerant of their condition and become good operative risks.

# PROSTATECTOMY—TRANS-SACRAL AND CAUDAL ANESTHESIA\*

A SERIES OF 40 CONSECUTIVE CASES.

ROBERT B. McIVER, A.B., M.D., F.A.C.S.  
Jacksonville.

The type of patient seeking relief for prostatic obstruction representing, as he does, the pathologic complexities of declining decades, is responsible for the high mortality that formerly obtained when the case was handled along general surgical lines. The recognition of the necessity for preliminary preparation, the development of clinical, bio-chemical and cystoscopic studies, the refinements of surgical technique, all leading to a reduction in mortality, constitute an advance that reflects credit to the workers in this particular field. Regional anesthesia is the most recent and not the least important factor in this progress. Elimination of general anesthesia, especially in border-line cases and poor risks, relieves the heart, lungs and kidneys of added strain, and affords that margin of safety often essential and always desirable.

Forty consecutive cases have been studied with particular reference to trans-sacral and caudal anesthesia; each case has been completely examined by an internist, has had repeated blood chemical and renal functional studies by the clinical laboratory, and has been cystoscoped, injected and operated, under a uniform technique. All cases seen during the time of this investigation have been operated, although several have required weeks of rest, elimination and digitalis, under the care of the internist, before the existing complications could be improved sufficiently. The supra-pubic, two-stage, operation was employed, except in four cases, when the cautery punch was used.

## Age:

Average age .....	68 years
Youngest .....	32 "
Oldest .....	91 "
Below 50 years.....	1
50 to 60 " .....	6
60 to 70 " .....	14
70 to 80 " .....	12
80 to 90 " .....	6
Above 90 years.....	1
	—
Total Cases .....	40

## Presenting Symptoms:

Frequency.  
Dysuria.  
Retention.

## Residual Urine:

Average .....	240 c.c.
Lowest .....	60 c.c.
Highest .....	1,600 c.c.

## Urine Output in 24 hours:

Before cystostomy—Average. . . .	1,200 c.c.
Before prostatectomy—Average. . .	2,800 c.c.

## Essential Laboratory Findings:

### 1. Phenolsulphonephthalein:

Before cystostomy—Average. . . .	38%
Lowest. . . .	10%
Highest. . . .	60%

### Before prostatectomy—

Average. . . .	65%
Lowest. . . .	50%
Highest. . . .	80%

### 2. Blood Urea:

Before cystostomy—	
Average. . . .	35 mg.
Before prostatectomy—	
Average. . . .	18 mg.

### 3. Blood Creatinin:

Before cystostomy—	
Average. . . .	2.5 mg.
Before prostatectomy—	
Average. . . .	1.3 mg.

## Additional Diagnoses after physical examination, listed in the order of the frequency:

Cardio-vascular-renal Disease.  
Arterio-sclerosis.  
Myocarditis with decompensation.  
Bronchitis—chronic.  
Bronchiectasis.  
Nephritis—chronic—Hypertension.  
Hernia—inguinal.  
Hydrocele.  
Calculus, prostatic.  
Calculus, uretral.  
Paralysis, spinal lues.  
Appendicitis, acute.  
Diverticula, bladder.  
Iritis.  
Epididymitis, specific.  
Papilloma, bladder.

\*Presented before the Annual Meeting of the Florida Medical Association, St. Petersburg, Florida, May, 1925.

Existing lesions were given appropriate preliminary treatment where possible or indicated. Cystoscopy was routine in this series. In some cases it was performed during supra-pubic cystostomy, employing the cystoscope directly through the opening in the bladder. With care

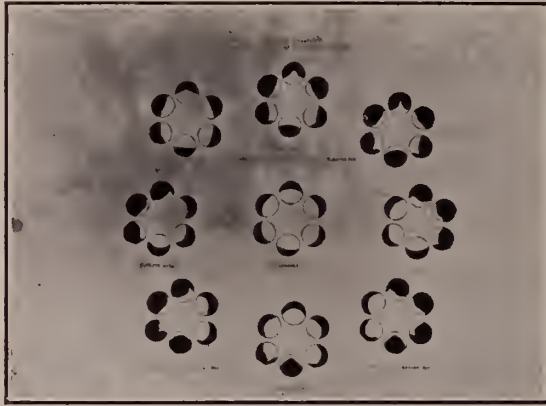


FIG. 1.

#### CYSTOSCOPIC VIEWS, PROSTATIC HYPERTROPHY.

Center—Normal Sphincter. Upper Left—Mild General Hypertrophy. Upper Middle—Moderate General Hypertrophy. Upper Right—Massive General Hypertrophy. Middle Left—Right Lobe Hypertrophy. Middle Right—Left Lobe Hypertrophy. Lower Left—Right Lobe and Median Lobe. Lower Middle—Median Bar. Lower Right—Left Lobe and Median Lobe.

this is possible without much delay or trauma, and without allowing the urinary retention to escape rapidly. Gradual, intermittent release of urine from a distended bladder to avoid congestion of vesical veins and of the kidneys should always be strictly observed. Introduction of the cystoscope per urethra was fairly comfortable under caudal injection alone, even in cases with considerable prostatic hypertrophy, a number 20-French observation instrument being used. Cystoscopy gives exact data regarding the location and character of the obstruction (Fig. 1) by changes observed in the contour of the internal sphincter, and aids materially in the selection of the type of operation to be employed. Calculi, vesical tumors and diverticulæ are discovered during this examination. Cases, that for good reason should not be subjected to cystoscopy, can be investigated by X-ray and the cystogram.

#### Technique:

Preliminary drainage of the bladder was accomplished under local anesthesia using 1/2% novocain with 3 m. adrenalin (1:1000) to the ounce. On the date set for the second stage a hypodermic consisting of morphine sulphate gr. 1/6 and scopolamin gr. 1/250 to 1/150 was given

one hour preceding operation. The room darkened and visitors excluded. To conserve time and to avoid disturbing the patient in the surgery, injections were done in the room 20 minutes before time for operation. This procedure allows: first, time for the injected solution to take effect; second, time for the operator, assistants and nurses to scrub; and third, time to transfer the patient into a prepared and quiet operating room.

In making the injections the anatomic types of sacra must be remembered. (Fig. II.) By turning the patient face downward on his bed and placing a pillow under the pelvis a convenient exposure is obtained. Palpating the posterior extremity of the ilium locates the posterior superior spine and a weal injected just below and externally overlies the second sacral foramen; passing the finger downward toward the crease in the buttocks identifies the posterior sacral cornu and a weal raised just below and externally overlies the fifth nerve exit. Two equidistant weals, that subdivide a line connecting the above points, will overlie the third and fourth foramen respectively. This procedure repeated on the opposite side indicates all trans-sacral injection points. A line connecting the right and left posterior sacral cornu forms the base of a triangle whose apex is the first segment of the coccyx; this triangle overlies the sacro-coccygeal membrane which is pierced in the caudal injection. The final weal is raised here. A column of 1/2% novocain is injected with a small calibre needle (26 gauge) from each weal down to the corresponding foramen or membrane. An empty needle (20 gauge—3 inches long) may be then introduced painlessly into each sacral foramen and through the sacral-coccygeal membrane into the sacral canal. If no blood or fluid escapes the novocaine is then slowly injected. We have routinely employed 1% freshly prepared sterile

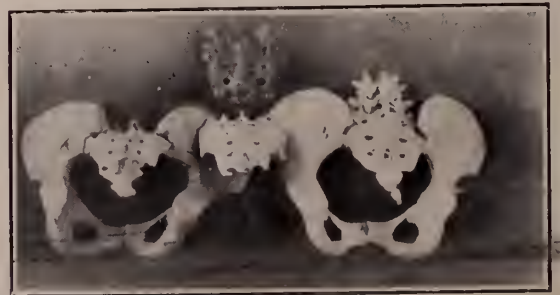


FIG. II.

THE SACRUM ANATOMIC TYPES.



novocain without adrenalin, injecting as follows: 20 to 30 c.c. in the caudal space and in the sacral. 10 c.c. at fifth, 9 c.c. at fourth, 8 c.c. at third and 7 c.c. at second on each side. A total of 88 to 100 c.c. of solution being used.

Fig. III illustrates the needles in position. The small pieces of adhesive overlie the bony landmarks indicated above. Where the needles have not entered a vessel (as indicated by blood flowing from its exposed end) and where the solutions have been injected slowly, we have seen no reactions. A few reactions encountered in a previous study was traceable to these causes.

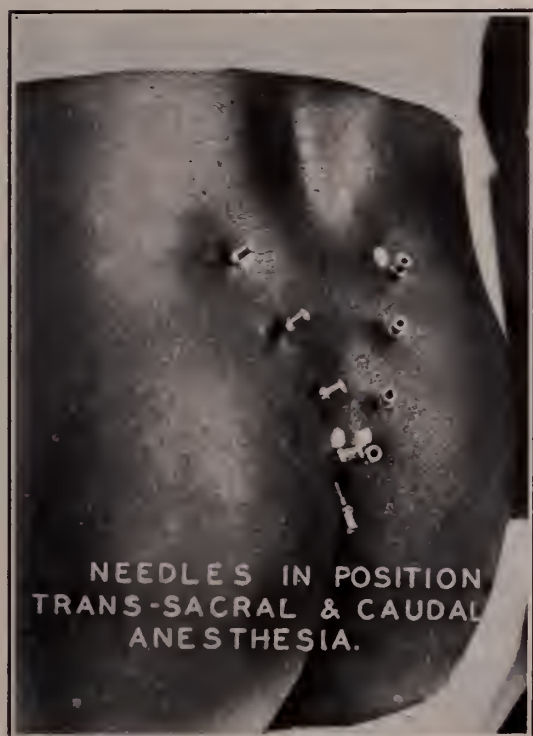


FIG. III.  
NEEDLES IN POSITION, TRANS-SACRAL AND CAUDAL ANESTHESIA.

After injection the patient was turned promptly on his back and in 10 minutes transferred quietly to the surgery, wearing a cold damp cloth over the eyes. Here the abdomen was promptly prepared and the supra-pubic sinus and lower recti muscles anesthetised by the block method using  $\frac{1}{2}\%$  novocain with adrenalin (1:1000) 3 m. to the ounce. Large quantities of solution (100-125 c.c.) were deemed important.

Enucleation of a large adenomatous prostate (Fig. IV) is usually accomplished quickly and without disturbing the sleep into which the patient has usually fallen from his hypodermic. Smaller and more fibrous glands (Fig. V) are

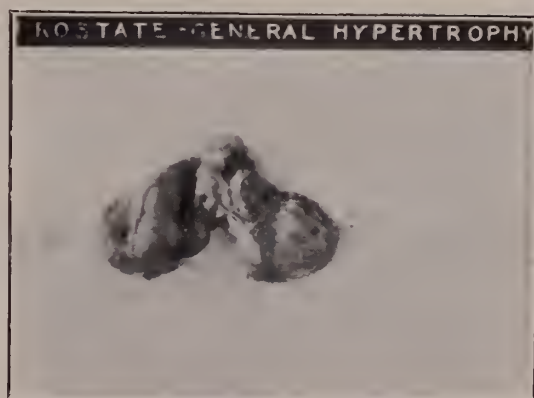


FIG. IV.  
PROSTATE—GENERAL HYPERTROPHY

The large type of adenoma is removed easily and without discomfort. The largest one in this series weighed 196 grams.

harder to remove and tearing through the urethra often induces temporary straining on the part of the patient. Sclerotic prostates and those containing calculi (Fig. VI) give the greatest percentage of imperfect results and failures from the standpoint of anesthesia. The time required in the operating room varies between 20 and 45 minutes with an average of 30 minutes in this series.

Stability of pulse, respiration and blood pressure observations before, during and after operation is gratifying to the big majority of prostatectomists who have employed regional anesthesia. Prompt and copious fluid intake by mouth often obviates the necessity of hypodermoclysis.

#### *Operative Results:*

Cases General Hypertrophy.....	28
Fibrosis .....	8
Median Bar .....	4
Total .....	40



FIG. V.  
GENERAL VIEWS—ADENOMATOUS AND FIBROUS PROSTATES.

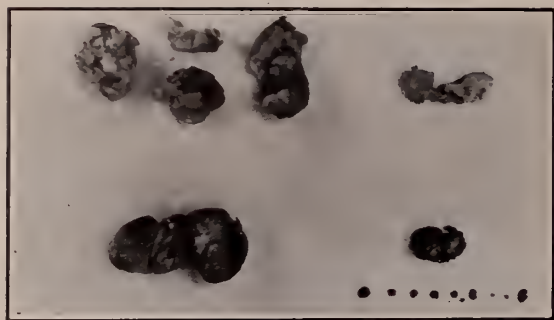


FIG. VI.

At Left—Adenoma (large) Prostate. At Right—Sclerotic Prostates, the lower complicated by 19 calculi.

Type Operation—	
Two Stage Supra-pubic.....	36
Cautery Punch .....	4
	—
Total .....	40
Mortality—	
Cases operated .....	40
Cases recovered .....	38
Cases died .....	2
Per cent mortality.....	4.4
Morbidity—	
Postoperative Fistula .....	0
Postoperative Incontinence .....	0
Postoperative Hernia .....	1
Complications—	
Broncho-pneumonia..... (Died)	1
Septicemia .....	1
Epididymitis (mild) .....	10
Orchitis (suppurative).....	1
Hemorrhage .....	1
Uremia .....	0

Anesthesia Results:

Failed (general anesthesia given).....	1
Fair (some pain).....	2
Poor (considerable pain).....	2
Excellent (including 15 that slept).....	35
	—
Total .....	40

Conclusions:

- 1. That trans-sacral and caudal injection is a distinct advance in the operative treatment of prostatic hypertrophy.
- 2. That in properly selected cases it is the anesthetic of choice.
- 3. That carefully administered it is safe.
- 4. That in a large percentage of cases the anesthesia is excellent.

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GRANULAR CALCIUM LACTO-PHOSPHATE SACCHARATED

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It is now conceded (Journal American Medical Association, October 3, 1925) that if calcium is furnished in sufficient quantity in the conditions for which it is indicated, cod liver oil, sunlight, or other measures in addition are not necessary. This, heretofore controversial point, being settled, there is only one other to be considered: the kind and quality of the calcium used. For intravenous injection only the chloride can be employed. And by the mouth the only logical form is the lacto-phosphate, because of its phosphorus content. As lime slakes in the air or is unstable in solution, it can only retain its potency and palatability by granulation with sugar. This simplifies its administration in a very satisfactory way. Physicians will find that where it is possible or necessary to administer calcium hypodermically once, they will give it by the mouth a hundred if not a thousand times. They need only one form, the granular, for this purpose, because it is readily soluble in water or may be swallowed straight. Probably the creation of granular calcium lacto-phosphate saccharated and its experimental use over a long period, and in many cases, to especially show its good effect in congestion of the lungs, when alcohol, its only supposed rival, is now discredited and legally barred, is an epoch making event in medicine. While not so sensational as the discovery of insulin, it will save more lives because of its wider applicability. Granular calcium is another step toward Medicine recovering its place beside Surgery from which it was dislodged by the discovery of Asepsis. As Nature does not furnish

a sufficient amount of calcium in ordinary food to supply the needs of the body in many conditions, it is evident that if it is supplied in a palatable, assimilable form in pregnancy, lactation, growing children, rickets, tetany, in acute wasting diseases to prevent debility and emaciation; in pneumonia and influenza to free the lungs from excessive secretion; in tuberculosis, and in hemorrhage from any cause, its effect on longevity is evident. Recently, an analysis of a number of makes of hypodermic tablets on the market showed they differed in strength from 30 to 70 per cent, and that was my experience when beginning the use of calcium. I found that in order to get the mineral with the necessary potency I had to have it specially manufactured, by what I consider the best chemical works in the world, and then granulated. The Army and Navy have dropped from their supply tables the hypophosphites because they were found to be absolutely inert, and I would like to suggest that you do not give the chloride by mouth because it is corrosive and poisonous, or any other form unless you investigate its chemical and physical condition. Only in this way will you give calcium a fair chance to show its effect. I could give from my case book a succession of cases of influenza, pleurisy, and pneumonia successfully treated with calcium, but prefer to describe my plan of treatment and let others try it if they will. The adult dose of granular calcium is two heaped teaspoons in half a glass of water every four hours and if administered early in the illness will mitigate all the symptoms and prevent some. The outstanding, astonishing thing is that it is a hypnotic, each dose causing sound refreshing sleep for four hours in a delirious patient. Even when there is pain it often avoids the use of morphine, although the latter is permissible when necessary. The blood in the sputum soon disappears, the fever lowers to a moderate point, and the cyanosis and breathing improve due to the prevention of osmosis into the lungs. Its action on the heart is ideal because it stimulates both the nerves and the heart muscle. In those cases which are not seen until well advanced and are so severe as to cause asphyxiation if the patient attempts to turn on either side, an additional small pillow placed under the right or left side of the face will give ease and facilitate sleep. Avoid annoying and disturbing with any kind of clay plaster, but a liniment of laudanum, aconite, and soap liniment is anodyne and satisfies the inherent instinct of mankind to rub something

on the sick. No laxatives of any kind, especially castor oil. No baths or rubs of any description until the acute stage is passed, and then only limb by limb with a basin of tepid water with a table-spoon of bay rum. Five feedings a day: 7 a. m., orange juice, oatmeal or hominy, milk, coffee; 10 a. m., hot malted milk; 12 noon, chicken, squab or beef broth, rice, mashed potato, custard, milk, demitasse; 4 p. m., grape juice and water, half and half, with a teaspoon of sugar, vanilla crackers; 6 p. m., milk, tea, crackers or toast, jelly. If they don't have all of this they get well just the same, for granular calcium is both medicine and food.

### SHALL PHARMACISTS SERVE PHYSICIANS?

SAMUEL S. DWORKIN,

*Chairman Committee on Biologicals, National  
Association of Retail Druggists and American  
Pharmaceutical Association,*

New York.

Biological products are becoming a greater factor in the modern materia medica every day.

Millions of patients are being treated with these products daily, and judging from the astounding results achieved by this form of medication, it is only in its infancy. Millions of dollars are being invested in research work in biological, chemical and pharmaceutical laboratories that represent an enormous capital investment.

Modern medicine in its scientific pursuits not only strives by these means to cure the scourge of many diseases that afflict mankind, but even greater attention is being given to the subject of preventive medicine as is shown by the extensive use of such biologicals as diphtheria toxin antitoxin mixture for immunization against diphtheria or authorized scarlet fever streptococcus toxin for active immunization against scarlet fever.

However, with all these advances in the science of medicine, little attention seems to have been given to the adequate and proper distribution of these important products.

It stands to reason that manufacturers of biologicals, chemicals and pharmaceuticals cannot maintain in addition to their research and manufacturing laboratories, distributing depots in all parts of the country where physicians can be promptly and efficiently served with their requirements day and night.



The question therefore arises, who shall be the logical distributor for biological products and other medicaments and what should be required of him?

A recent survey made throughout the United States reveals the fact that vast quantities of these products are being distributed in a more or less haphazard manner by supply houses who engage in this business largely in a commercial way only without any attempt to render a real professional service to the medical fraternity.

The proper storage under refrigeration, the prompt delivery of all orders, the selection and carrying stock of only products of the highest standards, the checking up of stocks of outdated potency, are only a few of the important duties that devolve upon the shoulders of the distributor.

Summing up all the factors that enter into the distribution of biological products, ampules for medication and other medicaments, who is better qualified and who should be looked to as the logical distributor of these products other than the professional pharmacist? The physician of today is one of the principal guardians of the public health and the professional pharmacist is the other.

It is most logical that there should be a closer bond of cooperation established between the medical and pharmaceutical professions if the well-being and health of the public at large are not to suffer.

Pharmacists are prepared and ready to serve physicians as professional men, and it is our belief that the medical fraternity will be served better, more efficiently and with a greater professional understanding if they will encourage pharmacists by looking to them as the logical distributors for biologicals, arsphenamines, insulin and medicaments of all kinds

The question of what the pharmacist should charge for his services as a distributor is one which also deserves discussion. As a rule, the professional pharmacist will only ask a fair percentage of profit to cover his overhead charges, such as rent, heat, light, clerk hire, maintenance of refrigeration, etc., on his sales to physicians for products to be used in their offices or for personal use.

However, too often when patients ask what the cost will be to them of certain medicaments prescribed for them, physicians unintentionally make the error of quoting the price at which they

themselves buy these same products for their own use. We know this is not the general practice, but feel that in justice to the professional pharmacist, and the service he renders, this erroneous practice should be brought to the attention of the medical fraternity.

We believe every physician will grant that the professional pharmacist is entitled to a legitimate margin of profit in excess of his overhead charges on sales he makes to the consuming public, whether such represent physicians' prescriptions or other products.

As a matter of professional pride, from the standpoint of service and sound economics, we offer this suggestion and also in the hope that we may hear constructive suggestions and criticisms from our friends in the medical fraternity. A broad discussion of this problem in all its phases will be welcomed, either by direct correspondence or through the columns of this publication with the permission of its editor.

Our mottoes are "Live and help to live" and "He who serves most serves best."

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#### WHAT SCIENCE MUST ACCOMPLISH

"The progress of medicine is the most important factor in the development of civilization. We ask from medicine the solution of the problems that are vital to the greatness and happiness of the human race.

"The purpose of medicine is to decrease human suffering by preventing disease or curing it. But this end cannot be reached except through a scientific understanding of the functions of the organism when modified by pathogenic factors.

"Scientifically organized hospitals and institutes for medical research, by merely continuing the investigations in which they are at present engaged, will immensely advance our knowledge of the nature and mechanism of disease. But fundamental principles have to be discovered; entirely new fields must be opened, and this can be accomplished only by pure science."—Alexis Carrel, *The Modern Hospital*, 26:299, (April) 1926.

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## THE COMMITTEE ON NECROLOGY

For several years the Journal has depended on the secretaries of the county medical societies for obituary notices. This duty has been grossly neglected or abandoned by the county secretaries. During the past year the grim reaper has been particularly unmerciful to our membership, and we lost through death several of our most faithful and beloved brothers. Of these the Journal printed an obituary notice of only one, and that was written and sent in by a friend of the deceased.

With a view toward correcting this condition, and in order that the death of a member will be promptly reported to the Journal and an obituary published, a committee on necrology has been appointed, with a member in each section of the State, serving a certain defined district. It shall be his duty to report the death of any member in his district to the Editor of the Journal, and to obtain a proper obituary notice, or resolutions of the local society, and send to the

Journal with a photograph of the departed member. In this we earnestly request the cooperation of the County secretaries with the members of the Committee.

Any man who has spent his life in the practice of medicine and has been a loyal member of our Association, very richly deserves this last tribute which the Journal is so anxious to pay. It is sincerely hoped that the Committee will function and this very important feature will no longer be neglected.

H. Mason Smith, M.D.

### THE DRIVE FOR MEMBERSHIP

The drive for the increase of membership which was so effectively started last year is being continued, and will reach its greatest momentum in the fall and winter.

The burden of this drive will fall heaviest on the Councilors, but the President is enlisting doctors over the State to assist the Councilors in this work. Beginning in September, the Councilors are expected to visit each County Society in their districts and do what they can toward improving and enlarging the societies and to organize societies in counties where there are none. Each Councilor will be furnished the names of doctors who are willing to go with him into these counties and assist in the organization work.

It is estimated that there are twelve hundred physicians in the State who should be in the Association, and the Association needs them. However, in our enthusiasm to increase our membership we should be careful not to take in one who does not measure up to the requirements of the Florida and American Medical Associations, but we want to get all who are entitled to the benefits of these organizations.

### THE HOSPITAL COMMITTEE

At various times in the past a Hospital Committee has been in existence, which has collaborated with the Council on Medical Education and Hospitals of the American Medical Association. This Committee has done some very effective and valuable work in Florida in this connection.

This field offers more opportunity for constructive work during the developmental period of Florida than any other within the province

of the Medical Association. The work has become of such important magnitude that a regular committee has been appointed to carry it on during the coming year.

The following physicians have been named to serve on this committee:

J. S. Helms, M.D., Chairman, Tampa.

J. E. Boyd, M.D., Jacksonville.

J. Q. Folmer, M.D., Chattahoochee.

H. M. S.

### STATE NEWS ITEMS

#### LAKELAND'S NEW HOSPITAL

The City of Lakeland has just completed what is conceded to be the most modern type of hospital building and equipment to be found anywhere in the country.

It was largely due to the initiative of the Medical Fraternity of Polk County that the interest of the people was aroused, followed by an almost unanimous willingness on the part of the voters to provide ample and adequate hospital facilities, not only for Lakeland alone but for that large and thickly populated section of southwest Florida, of which Lakeland is the central point. Approximately three years were required in the way of a campaign of education which not only resulted in the creation of this present plant but in bringing into close ethical relationship the members of the medical fraternity, and incidentally establishing a very friendly attitude between the Polk County Medical Society and the people at large. In other words, the new Morrell Memorial Hospital marks an era of cooperation in this particular field of service that otherwise never could have existed. The people feel that Morrell Memorial Hospital is their hospital and that they have provided this avenue of service to the people through the medium of those engaged in the practice of medicine and surgery.

While not the largest building of its kind in the South, the new hospital, in the matter of convenience, substantial construction, modern facilities, and comforts for both patients and physicians, stands unequalled. In fact, it is the last word in hospital construction and equipment. Along with the building there is to be provided this year a residence for the Nurses' Staff and for the Student Nurses, to be erected at a cost of seventy-five thousand dollars for the building alone. The furnishings will be in keep-



ing with the handsome type of building to be erected, recognition being given by the people of Lakeland in voting an additional appropriation of the service rendered by the self-sacrificing women who are giving their lives, not for selfish gain but for the sake of humanity.

The entire investment in grounds, building and equipment will be approximately one-half million dollars and is planned to take care of one hundred patients.

The building is a combination of Spanish and Italian design. Reinforced concrete frame with hollow tile walls and stucco finish. The entire building is absolutely fire-proof, so far as human ingenuity can make it so. There are four stories, including the ground floor, or basement, and in addition, a roof garden over practically the entire area of the building proper. The location of this hospital is on the new northern entrance to Lakeland, known as the Lakeland Hills Boulevard, which is in reality a continuation of the State Highway No. 2, extending from the Georgia line through central Florida to Fort Myers. It overlooks the wide expanse of Lake Parker, one of Lakeland's numerous bodies of fresh water, and is the most conspicuous object brought to the traveler on entering the city from the north. The surrounding grounds are now being landscaped by an expert and will add tremendously to the attractiveness of the setting. The building itself is quite imposing with its wide and beautifully proportioned front, there appearing on the main wall, in iron letters, the name of the institution.

A wide driveway branches from the main entrance and continues to the rear of the hospital, where ambulances enter a covered porch-way and where the patients are removed and, unless emergency cases, can be placed on the beds which they are to occupy while in the hospital. They are then taken to the elevator and to the private room or ward set aside for their accommodation. Emergency cases are removed to the emergency room where facilities are available for prompt attention, such as a marble wash slab, sterilizer, and other equipment there available. The patients so treated are then removed to the place set aside for them in the hospital, or can be taken directly to the operating rooms on the third floor.

On the south wing of the ground floor are the dining rooms for the nurses' staff, both permanent and student, all nicely furnished and ex-

tremely comfortable. Here are also the refrigerating and heating plants in addition to the electrical equipment, all of the very latest type. The kitchen is in the west wing and is the last word in the matter of equipment and convenience. It is electrically operated throughout, but with gas and steam connections. From a sanitary and technical standpoint it is rated perfect. In the northern wing of this floor is the pathological laboratory and the assembly rooms for nurses' class work. Also a quiet room and family room for patients dying, where the family may assemble at the bedside without interfering with the routine of the hospital.

The first or main floor is reached by a wide terrace and tier of tiled steps. The entrance itself is exceedingly pleasing, there being a rotunda, on the north side a reception room for patients coming in and waiting. On the left are the offices of the superintendent and the executive staff, together with the general information office. On this and the other three floors run long corridors from one end of the building to the other, terminating at either end in wide open sun-parlors. On this main floor are the wards, medical and surgical and children's wards. They are all furnished with the latest type Gatch Bed.

The third floor contains the private rooms, twelve of which have private baths, with the same type of equipment throughout.

In the north wing of the fourth floor is the Surgical Department, entirely shut off from the other part of the building, where are located two of the finest operating rooms of any hospital in this country, both in the matter of light and equipment. In addition to this they have an eye, ear, nose and throat operating room, with sterilizing rooms, nurses' rooms, doctors' locker-rooms and scrub rooms. Immediately adjoining this is the X-ray Department, fully equipped in the very latest X-ray laboratory. On the west wing is the Delivery room, Nursery and Obstetrical Department.

One feature of the Morrell Memorial Hospital that is quite unusual and that gives it a distinction is a roof garden, which has been so planned that patients can readily be taken from their rooms or wards to the roof, not alone for the fresh air and sunshine, but for the exhilarating effect of one of the most beautiful panoramas of lake, groves, hills and driveways to be found anywhere. Another feature that is quite unusual, and is the result of the thoughtful interests

of the Rotary of Lakeland in cooperation with the City authorities, is the installation of a Radio system by which every patient in the hospital will have the enjoyment of radio programs through the simple adjustment of a head-piece placed at each bed. In addition to this are loud speakers located in all the sun-parlors and on the roof garden.

#### LUNCHEON PRECEDED OPENING

A few days before the actual opening occurred the City of Lakeland entertained at luncheon at Cleveland Heights Club House the members of the Polk County Medical Society and the Polk County Press Association. This was attended by some fifty leading men of both professions, the occasion being a most happy one, bringing together as it did many of the most prominent surgeons and physicians in Tampa, Ocala, Jacksonville, Orlando, Plant City, Fort Myers and from all parts of Polk County.

Doctor E. B. Milam, of Jacksonville, accompanied by his wife and children, left recently for a visit in Kentucky. Following this, Doctor Milam expects to spend several months at the New York Post Graduate school doing special work in Gastro-Enterology. Doctor Milam will be absent from Jacksonville about two months.

Doctor M. A. Lischkoff, of Pensacola, is spending the summer in Europe. He expects to visit the ear, nose and throat clinics in London, Paris, and Vienna. During his absence from Pensacola, Doctor C. J. Heinberg, who is associated with him, is looking after his practice.

Born to Doctor and Mrs. E. F. Carter, 2702 Jetton Avenue, Tampa, Barbara Clair Carter, May 24, 1926.

Doctor George E. Weems, of Apalachicola, was a recent visitor in Jacksonville.

Doctor H. Marshall Taylor, of Jacksonville, has just returned from attending the meetings of the American Otological Society and the American Laryngological Society held in Montreal, Canada.

While at the Gainesville meeting, a number of men got together and organized the Florida State Medical Golfers' Association. The follow-

ing officers were elected: Joseph Halton, Sarasota, president; J. S. McEwan, Orlando, vice-president; W. M. Manning, Jacksonville, secretary; and Joseph Taylor, Tampa, treasurer. The membership fee is \$1.00. All golfers who are members of the Florida Medical Association are requested to become members of this Association, remitting \$1.00 membership fee to Joseph Taylor, M.D., Tampa, Florida. At the meeting next year at West Palm Beach, a three-day tournament will be held and all members are urged to bring their golf clubs. On the evening of the third day, a stag dinner will be held at which the prizes will be presented.

The regular monthly meeting of the Volusia County Medical Society was held at Daytona Beach on May 18th. Doctor S. R. Norris and Doctor L. W. Holloway from Jacksonville were visitors at the Society. Doctor Norris read a paper, the title of which was "The Conduct of Labor." The paper was followed by a general discussion by members of the Society.

Doctor and Mrs. J. C. Chandler, of Tampa, attended commencement exercises at Riverside Military Academy, Atlanta, Georgia. They spent several days in Athens, Georgia, the home of Doctor Chandler.

Doctor J. C. Davis, Jr., of Quincy, Florida, served as a fraternal delegate at the meeting of the Georgia Medical Association which held its meeting at Albany, Georgia, during the past month. This custom of appointing fraternal delegates by the Georgia and Florida Medical Associations will tend to bring about a kindlier feeling between the respective Associations and will be instrumental in stimulating an understanding between the organizations of these States.

Doctor C. H. Farmer, who for the past few months has been connected with the Florida State Board of Health in the capacity of Medical Officer for the Jacksonville District, left the State Board of Health on May 15th to begin the practice of medicine in Lakeland, Florida. For the past three years he has been connected with the South Carolina State Board of Health. On moving to Lakeland, Doctor Farmer will be associated with Drs. C. W. Love and George C. Overstreet, with offices in the Marble Arcade.

Doctor G. C. Kingsbury, practicing physician at Largo, Florida, died suddenly Wednesday, May 19, 1926, at the age of sixty-seven. Doctor Kingsbury graduated from the Miami Medical College of Cincinnati, Ohio, in 1880 and was licensed to practice medicine in this State in 1908. He was a member of the Pinellas County Medical Society and a Fellow in the American Medical Association.

Doctor Blackburn W. Lowry, of Tampa, is visiting his mother who is confined to a hospital in Philadelphia. Doctor Lowry expects to visit New York while on this trip.

The Women's Auxiliary of the State Medical Association, organized at Gainesville, should be a great help to organized medicine in the State. A Chapter of this organization should be organized in each county where there is a component society. They should be represented at the next State Medical Association, where regular meetings will be held, with committee reports, and other things of vital interest to the Medical Association. The ladies should by all means encourage membership in the county societies and attendance at the State meetings.

The president of the Medical Association, together with the former president, are heartily in favor of this organization and are looking forward to its being a great help in carrying out local and state policies which they hope to promote during the coming year.

We hope Mrs. Lassiter, of Gainesville, who was elected president, will not lose any time in getting her organization in working order so that our next meeting in West Palm Beach will be the greatest of State meetings for organized medicine in Florida. Many State Medical Associations have well-organized Auxiliaries, so why not Florida?

Doctor Earl H. McRay, of Tampa, is in Baltimore, being called there on account of the ill health of his father.

The executive committee of the Association, consisting of Doctor G. R. Holden, chairman, Jacksonville, Doctor Sheldon Stringer, Tampa, and Doctor C. D. Christ, Orlando, met in session in Jacksonville, May 25th. Many matters pertaining to the administration of the State Association were discussed. The most important matter to come before this committee was the matter of payment of past obligations to the

Record Printing Company. Payment was arranged for, and the Association is out of debt for the first time since 1914. A full report of this indebtedness was contained in the secretary-treasurer's report as presented at the annual meeting in Gainesville.

#### STATE BOARD OF HEALTH NOTES

At the conference of State and Provincial Health Authorities of North America, held at Atlantic City May 21 and 22, 1926, Dr. M. M. Seymour, Health Officer of Saskatchewan, the President of the Conference, in his address, suggested that a country-wide immunization program be staged against diphtheria, smallpox and typhoid. His suggestion was approved, and it was unanimously resolved that with the opening of the schools in September the program would be commenced, and that diphtheria immunization would be carried on during September and October. That following this a campaign against smallpox would be waged in November and December, and that during January and February, 1927, the fight against typhoid would be carried on.

By making this a country-wide plan much good should be accomplished.

At the meeting of the Florida League of Municipalities, at Pensacola, June 2 and 3, this matter was discussed and the League voiced its approval and support of the program.

These are diseases we know how to prevent, hence, a case of any of them indicates a lack of civic pride on the part of the patient or the one responsible for the health of that individual.

Every physician in the State can help his patients and his community by calling this campaign to the attention of those with whom he comes in contact.

Remember, the State Board of Health furnishes the material for immunization, and you may get it by writing the nearest laboratory, but requests for any large amount should be addressed to the laboratory at 2nd and Julia Sts., Jacksonville, as that is the main distributing point.

Dr. J. R. Bean, Director of the Bureau of Laboratories, has been at the point of death in Walter Reed Hospital following an operation for brain tumor at Johns Hopkins Hospital in April. Until a very short time before he went for operation no one suspected his condition, and the knowledge of it came to us as a great shock.



SCHEDULE OF MEETINGS—COMPONENT SOCIETIES  
FLORIDA MEDICAL ASSOCIATION

MEETINGS					
County Society	Secretary	Date	Time	Place	Luncheon?
Alachua .....	W. Lassiter, M.D., Gainesville.				
Bay .....	J. M. Nixon, M.D., Panama City.				
Bradford .....	Seeber King, M.D., Lake Butler.				
Brevard .....	R. D. Ferguson, M.D., Titusville.				
Broward .....	R. Hippensteel, M.D., Ft. Lauderdale.	Monthly	8:00 P.M.	Ft. Lauderdale High School	No.
Columbia .....	L. J. Arnold, M.D., Lake City.				
Dade .....	G. Raap, M.D., Miami.	1st Friday	8:30 P.M.	Miami City Club	Occasionally.
DeSoto .....	C. H. Kirkpatrick, M.D., Arcadia.			Hospital	No.
Duval .....	Louie Limbaugh, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Arnold-Edw. Auditorium	No.
Escambia .....	Herbert D. Snyder, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.
Hillsboro .....	R. W. Lowry, M.D., Tampa.	1st and 3rd Tues- days	8:00 P.M.	City Hall	No.
Jackson .....	R. L. Kennedy, M.D., Malone.	2nd Tuesday	3:00 P.M.	Marianna	No.
Lake .....	S. C. Colley, M.D., Tavares.	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.
Lee .....	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.
Leon-Gadsden .	F. Clifton Moor, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.
Manatee .....	J. M. Davis, M.D., Bradenton.				
Marion .....	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.
Monroe .....	G. R. Plummer, M.D., Key West.				
Orange .....	M. M. Andrews, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Announced	No.
Palm Beach ...	W. O. Arnold, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Varies	Yes.
Pasco .....	T. F. Jackson, M.D., Dade City.	2nd Tuesday	8:00 P.M.	Varies	Yes.
Pinellas .....	O. O. Feaster, M.D., St. Petersburg.	Every 2nd Friday	8:00 P.M.	Fla. Art School	No.
Polk .....	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr. June, Aug. Oct., Dec.		Lakeland	Yes.
St. Johns .....	I. M. Hay, M.D., St. Augustine.				
St. Lucie-Okeechobee .....	G. C. Hardie, M.D., Ft. Pierce.				
Sarasota .....	F. Metzger, M.D., Sarasota.				
Sumter .....	W. E. Mitchell, M.D., Coleman.	Monthly			No.
Taylor .....	R. J. Greene, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.
Volusia .....	R. L. Miller, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.
Walton .....	D. H. Simmons, M.D., DeFuniak Springs.	3rd Thursday	8:00 P.M.	Varies	Occasionally.

## NOTE

(Secretaries: Please submit information to complete the above schedule.)

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